Orthopedic & Spine Center
Theraplay LLC
4651 W Vernal Pike
Bloomington, IN 47404
Telephone (812) 332-7529 Fax (812) 339-7529
Email: customerservice@theraplayspine.com

Patient Information

Date: _____ **Date of Birth:** _____ **Age:** _____

First Name: _____ **Middle:** _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

SSN: _____ **Sex:** ☐ **Male** ☐ **Female** **Occupation:** _____

REMINDER: ☐ **Email** ☐ **Phone** ☐ **Text/Provider:** _____

Cell: _____ **Home:** _____ **Email Address:** _____

Emergency Contact Name: _____ **Phone:** _____

Relationship to Patient: _____

Health History

Primary Care Doctor: _____ **Referral Doctor:** _____

Date of next doctor's appointment: _____

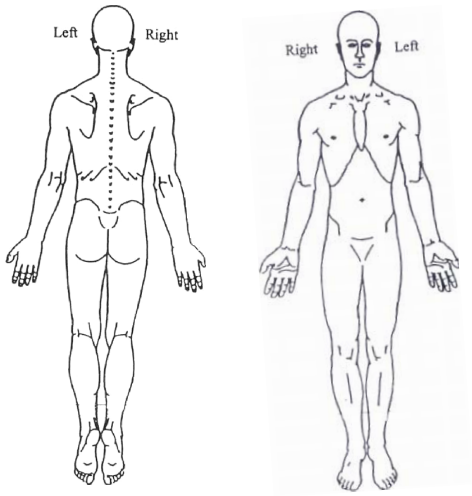
Medical Condition	Yes	Medical Condition	Yes	Medical Condition	Yes
High Blood Pressure		Cancer: Type		Subluxed/Dislocated joints	
Heart/Circulation disorders		Kidney Disease		Slipped/Ruptured Disc	
Stroke		Hepatitis		Scoliosis	
Chest pain/Discomfort		Immune deficiency disease		Painful Grinding	
Fatigue/Energy Loss		Tuberculosis		Sprains/Strains Joints	
Diabetes		Hernia		Broken Bones	
Headaches		Loss of Bladder/Bowel		Falls	
Seizures		Arthritis		Limited Range of Motion	
Dizzy Spells		Fibromyalgia		Ankle Swelling	
Anemia		Osteoporosis		Others:	

Please CIRCLE the number that represents your pain level.

0 = no pain & 10 = severe pain

AT WORST:	0	1	2	3	4	5	6	7	8	9	10
AT BEST:	0	1	2	3	4	5	6	7	8	9	10
CURRENTLY:	0	1	2	3	4	5	6	7	8	9	10

Mark the location of your pain with an "x"



Are your Symptoms:

☐ **Constant** ☐ **Come & Go** ☐ **Ache** ☐ **Superficial**

☐ **Dull** ☐ **Shooting** ☐ **Sharp** ☐ **Burning**

☐ **Deep** ☐ **Numbness/Tingling** ☐ **OTHER:** _____

1. **Are your symptoms:** ☐ **Improving** ☐ **Getting Worse** ☐ **Staying the same**

2. **Have you ever had this symptoms before?** ☐ **YES** ☐ **NO** **Description:** _____

3. **Does your pain seems to be WORSE at certain time of a day?** ☐ **YES** ☐ **NO**

   If Yes, ☐ **Morning** ☐ **Night** ☐ **Other:** _____

4. **Does your pain progress as the day goes along?** ☐ **YES** ☐ **NO**

5. **Do you have difficulty falling asleep?** ☐ **YES** ☐ **NO**

6. **Do you wake up due to pain?** ☐ **YES** ☐ **NO** **If Yes, # of times per night:** _____

7. **Is there any particular activity that aggravates your symptoms?** _____

8. **Have you ever had treatment before this symptoms?** ☐ **YES** ☐ **NO**

   If YES, please describe:

   ☐ **Medication: Beneficial?** ☐ **YES** ☐ **NO** **EXPLAIN:** _____

   ☐ **Injection: Beneficial?** ☐ **YES** ☐ **NO** **EXPLAIN:** _____

   ☐ **Therapy: Beneficial?** ☐ **YES** ☐ **NO** **EXPLAIN:** _____

   ☐ **Chiropractor: Beneficial?** ☐ **YES** ☐ **NO** **EXPLAIN:** _____

9. **Have you had any testing:** ☐ **CT scan** ☐ **MRI** ☐ **EMG/Nerve Conduction Test** ☐ **X-ray**

   ☐ **OTHER** **RESULTS:** _____

10. **Did you have surgery?** ☐ **YES** ☐ **NO** **Date of Surgery** _____

    If yes, what procedure did you have done? _____

11. **Do you have any metal (excluding teeth) in your body?** ☐ **YES** ☐ **NO** **i.e. pins, plates, and pacemaker.**

    Where? _____

12. **Allergies:** ☐ **YES** ☐ **NO** **If Yes, please describe** _____

13. **For women, are you pregnant?** ☐ **YES** ☐ **NO**

14. **Injury related to:** ☐ **WORK** ☐ **MVA** ☐ **Other** **Date of Injury:** _____

15. **Have you had Physical Therapy treatment this year?** ☐ **YES** ☐ **NO**

    If yes, please indicate type of treatment and duration: _____

16. **For MEDICARE PATIENTS ONLY: Are you currently receiving Home Care Services?** ☐ **YES** ☐ **NO**

Do you have a Homecare Discharge Letter? **YES** ☐ **NO** ☐ **Discharge Date:** _____

17. **PATIENT GOALS FOR THERAPY:**

_____

NO SHOW AND LATE CANCELLATION POLICY: Appointments not cancelled 24 hours prior to scheduled appointment time and no show appointments will be assessed a fee of $25.00. These charges are the patient's responsibility and will be billed directly to them. Following 3 no shows/late cancellations, any further appointments will be removed from the schedule.

I acknowledge I am aware of the no show and late cancellation policy and will be responsible for any fees assessed for this policy.

Signature of Patient or Legal Guardian: _____ Date: ____/____/_____

ASSIGNMENT & RELEASE: I, assigned Theraplay LLC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due and owing for services rendered by Provider including, without limitation, reasonable attorney's fees.

I hereby authorize Theraplay LLC, to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission whether manual or electronic.

Signature of Patient or Legal Guardian: _____ Date: ____/____/_____

CONSENT TO TREAT: I, hereby request and consent to THERAPLAY LLC to perform rehabilitative treatment and care as prescribed by my physician and/or recommended by my physical therapist. I understand and am informed that, as in the practice of physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my condition, prior to treatment. I authorize the physical therapist to perform any additional or different treatment, which is deemed necessary should, during treatment, a condition be discovered which was not known previously. I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss my condition with the treating physical therapist. I consent and authorize THERAPLAY LLC (including students in training) to administer treatment under the direction and supervision of the physical therapist.

Signature of Patient or Legal Guardian: _____ Date: ____/____/_____

NOTICE OF PRIVACY PRACTICE: I understand that, under the Health Insurance Portability & Accountability Act ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand (or have been given the option) your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

▢ I chose not to obtain a copy of this organizations *Notice of Privacy Practices* but I am aware of my right to do so at any time.

Signature of Patient or Legal Guardian: _____ Date: ____/____/_____