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Advanced Institute of
Physical Therapy

PERSONAL MEDICAL DATA FORM

PERSONAL INFORMATION

Name: _____ DOB: _____

Address: _____

_____ _____ _____

City State Zip code

Cell Phone: _____ Home Phone: _____

E-mail address: _____

Emergency contact/relationship: _____ Phone: _____

Occupation: _____

Please check any of the following symptoms you have experience in the past six months.

☐ Upper back pain	☐ Shoulder pain	☐ Tingling/Numbness	☐ Fatigue/Depression
☐ Lower back pain	☐ High Blood Pressure	☐ Dizziness/Vertigo	☐ Muscular Aches
☐ Headaches	☐ Stiff Neck	☐ Constipation	☐ Carpal Tunnel
☐ Stomach	☐ Allergies	☐ Osteoporosis	☐ Arthritis
☐ Fibromyalgia	☐ Bruising disorders	☐ Vision change	☐ Asthma
☐ Heart problems	☐ Sinus Problems	☐ PMS Problems	☐ Bladder Problems

How long have you suffered these symptoms? ___ weeks ___ months ___ years

Have you ever had an accident?

_____ Auto ___/_____ (MM/YYYY) _____ Work ___/_____ (MM/YYYY)

_____ Other ___/_____ (MM/YYYY) _____ None

HEALTH INSURANCE

Information below is to check coverage ONLY

Do you have medical insurance? Please select the coverage you have.

☐ Medicare	☐ Tricare	☐ WPS VA	☐ UHC	☐ UHA
☐ HMSA/BCBS	☐ HMA	☐ HMAA	☐ Ohana	☐ Ohana SMG
☐ Devoted	☐ MDX	☐ Humana	☐ UFCW-HI	☐ Aloha Care
☐ HMO	☐ PPO	☐ HPH	☐ Quest	☐ Other

Policy Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber DOB: _____

1 (808) 600-9148
info@movementplus.com
movementplus.com

Aiea
98-1005 Moanalua Road,
SPC 410 Aiea, HI 96701

Honolulu
1401 S. Beretania St., Ste
888 Honolulu, HI 96814

Waipahu
94-216 Farrington Hwy.,
Ste A-102 Waipahu, HI 96797

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For **Work** Related Injuries:
Name of Employer: _____ Phone: _____
WCOMP Insurance: _____ DOI: _____ Claim No.: _____
Adjuster Name: _____ Phone: _____ Fax: _____

For **MVA** Related Injuries:
Name of Employer: _____ Phone: _____
MVA Insurance: _____ DOI: _____ Claim No.: _____
Adjuster Name: _____Phone: _____ Fax: _____

Do you have an attorney for your accident or injury? ___ Yes ___ No
If yes, please fill out the following:
Attorney's Name: _____ Phone: _____ Fax: _____

ACKNOWLEDGEMENTS

To set clear expectations, improve communications, and help you get the best results in the shortest amount of time, please read each statement, and initial your agreement.

Initials

_____ I instruct the provider to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health.

_____ I acknowledge and may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I realized that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I received.

_____ I acknowledge that I have informed the front desk of any and all insurance(s) I have. I have not withheld any additional insurance information. I understand that I will be fully financially responsible for giving false information in regards to my insurance.

_____ I acknowledge that should any of my insurance information change (i.e., plan type, subscriber, etc.) I will immediately inform the front desk.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

_____ **I acknowledge that a 24-hour cancellation notice is required. Without proper notification a missed appointment may result in a $30 cancellation fee.**

If the patient is a minor child, print child's full name: _____

Signature: _____ Date: _____

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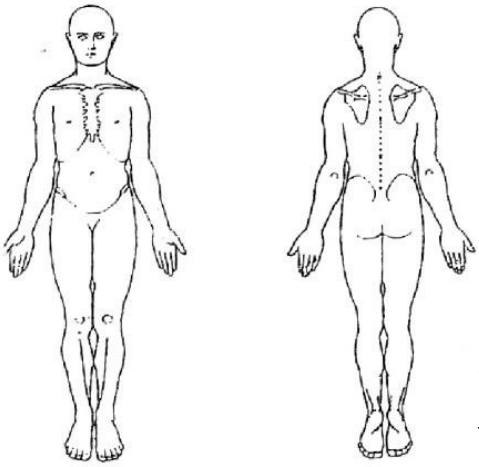
Name: _____ DOB: _____

Referred by: _____

Chief complaint: _____

Put an "X" for current pain



Rate your pain on the scale below.

When did the problem begin? _____

Has the problem affected your daily life? (i.e., job and exercising) _____

_____

_____

Have you had previous or similar occurrences of these symptoms? ___ Yes ___ No

If yes, please describe _____

_____

Date of special tests (MRI, X-ray) and findings: _____

_____

Past medical history with dates (accidents, injuries, falls, surgeries): _____

_____

Current medications: _____

What are your current physical activities and how have they changed? _____

_____

What are your goals and expectations of physical therapy? _____

_____

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CONDITION AND CONSENT FOR OUTPATIENT TREATMENT

In order for physical therapy to be most effective, I understand that:

COOPERATION WITH TREATMENT

I must attend my appointments as scheduled unless there are unusual circumstances that could prevent me from attending therapy. I understand that I may be discharged from physical therapy if I fail to keep three (3) appointments without calling at least 24 hours in advance to cancel. I agree to cooperate with the home program assigned to me. If I have difficulty fulfilling my program, I will discuss this with my therapist.

NO GUARANTEE

The staff of the physical therapy department does not promise me a cure for my condition. They will share with me the available statistics and studies regarding the results of physical therapy treatment for my condition. They will discuss all treatment options with me.

INFORMED CONSENT TO TREATMENT

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The staff of the physical therapy department provides a wide scope of services and will dispense information at the initial visit on the treatment/assessment options available for my condition.

POTENTIAL RISKS

I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is generally temporary and will probably subside in 24 to 48 hours.

POTENTIAL BENEFITS

I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may also experience decreased pain. Ultimately, I will have greater knowledge about managing my condition and the resources available to me.

ALTERNATIVES

All physical therapy treatment options available for my condition will be explained to me. I may inquire on the cost of these services and discuss them with my therapist. If I do not wish to participate in the program, I may discuss my medical, surgical, or pharmacological alternatives with my physician.

INSURANCE INFORMATION

As a courtesy to you, we will bill your insurance company. But it is your responsibility to know your policy benefits and limitations. Any portion of your treatment that is not covered by your insurance becomes your responsibility. For workers compensation and MVAs claims, please be advised that you are financially responsible for all charges in the event that your claim is denied.

Based on the information I have received from the therapist; I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

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