

PTFW

Business Office

Phone: 817-247-1130

Fax: 817-292-7930

Treatment Locations:

Fort Worth

Dallas

Colleyville

Dear Valued Patient:

Welcome to PTFW. It is my goal to provide you with therapy that will help you reach your maximum potential. Cooperative effort is the key to success in your therapy treatment. Cooperation not only with you, but also with your physician, other health care providers, and your family is important in obtaining your goals.

At PTFW, **I look at the person as a whole**, not just the body region that is impaired. I am privileged to work with other health care providers as an interdisciplinary team, taking into account the whole person. Each treatment session includes direct treatment, consultation, home programming, and documentation of the services. Direct treatment addresses the goals and objectives established in your treatment plan. Consultation includes updating current issues and concerns. Home programming involves patients and family members in the overall success of treatment. Documentation at the time of service assures accurate documentation of the events of the session. You may expect the direct therapy portion of your session to end approximately 5 minutes before the scheduled end of your session to allow time to document the events and to clarify your questions.

One of my goals is to begin and end sessions in a timely manner. I recognize that your time is valuable. Therefore, if there is ever a time when you have not been escorted into treatment within 10 minutes following your scheduled appointment, please inform the receptionist. In order for your treatment plan to be effective, you must adhere to the appointments as they have been recommended and scheduled. Should an occasion arise that you will be unable to keep your scheduled appointment, I ask that you call in advance to reschedule your appointment. You may lose your regularly scheduled treatment time or be discharged from therapy if you miss 3 appointments without notifying the office in advance and/or you may be charged for those missed sessions. This is a courtesy to all of the patients and staff, so that we are optimizing our appointments to everyone's benefit.

I welcome you to PTFW, and trust that you will achieve your maximum potential of rehabilitation. I look forward to serving you, while reaching and improving upon my standards of excellence.

Sincerely yours,

PTFW

Please note that we are a perfume/cologne-free environment, due to sensitivities of customers and staff.

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PATIENT INFORMATION

Patient's Name _____ DOB _____ Age _____

Street _____

City _____ State _____ Zip Code _____

Phone #'s:(H) _____ (Cell) _____ (W) _____

Occupation _____

Employer _____ E-mail _____

Do you Text? Yes No

Spouse Information

Name: _____ Emergency Contact: _____

Telephone _____ Alternate Phone: _____

Employer: _____ Occupation: _____

Who may we thank for your referral? _____ Physician _____

Diagnoses _____

I understand that I am responsible for my bill.

Signature _____ Today's Date: _____

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CONDITIONS AND CONSENT FOR OUTPATIENT EVALUATION AND TREATMENT

I. COOPERATION WITH EVALUATION AND TREATMENT:

- A. I understand that in order for therapy to be effective, I must come as recommended and scheduled unless there are unusual circumstances that prevent me from attending therapy.
- B. I understand that I may be discharged from therapy if I fail to keep three (3) appointments without calling to cancel.
- C. I agree to cooperate with the home program assigned to me. If I have difficulty, I will discuss this with my therapist.

II. NO WARRANTY:

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

III. INFORMED CONSENT TO EVALUATE AND TREAT

The term "informed consent" means that the potential risks, benefits and alternatives of the therapy evaluation and treatment have been explained to you. The facility provides a wide scope of services and you will receive information at the initial treatment session on the treatment options available for your condition.

1. **Potential Risks:** If your evaluation or treatment is for musculoskeletal or neurological dysfunction, you may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury. This discomfort is typically temporary and will probably subside in 24 hours.
2. **Potential Benefits:** These include an improvement in your symptoms and/or an increase in your ability to perform your daily activities. You will have greater knowledge on managing your condition and the resources available to you. If your treatment sessions are for musculoskeletal or neurological dysfunction, you may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain.
3. **Alternatives:** If you do not wish to participate in the recommended evaluation or treatment program, you may discuss this with your therapist.
4. **Treatment may consist of:** CranioSacral Therapy, Visceral Mobilization, Myofascial Release, Strain/Counter Strain, Deep Tissue Mobilization, Muscle Energy Techniques, Lymph Drainage, and various other massage therapy techniques.
5. **Body Parts to be treated:** Any part of the body may have fascial restrictions. Appropriate draping will always be utilized. If you are uncomfortable for any reason, you may request your treatment to be terminated at any time, and the session will end.

Based on the information I have received from the therapist, I voluntarily consent to a therapy evaluation and/or treatment. I understand that I may withdraw at any time.

PATIENT'S SIGNATURE

PATIENT'S PRINTED NAME

DOB

DATE

THERAPIST'S SIGNATURE

THERAPIST'S PRINTED NAME

DATE

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FINANCIAL INFORMATION FOR PATIENTS

CHARGES AND PAYMENTS: PTFW's fee schedule and payment options can be discussed prior to the rendering of services. Payments are due when services are rendered. To keep your costs lower, only checks or cash are accepted for payment. PTFW will charge a return check fee of **\$30.00** per returned check. Returned check fee must be paid in cash.

CANCELLATION: Your appointment time is scheduled specifically for you, therefore PTFW requires prior notification of cancellation of all therapy sessions. Failure to cancel an appointment may result in billing for the full regular fee. Third party reimbursement **does not** pay for unattended sessions, therefore "no show" charges will not be reimbursed by your insurance.

Payment in full is required at the time services are rendered.

Patient/Guarantor Signature

Printed Name

Date of Birth

Date

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MEDICAL HISTORY FOR THERAPY EVALUATION

Patient: _____ DOB: _____ Today's Date: _____

Occupation: _____ Currently working? Yes No #Hrs/day _____ # Days/wk _____

Physical requirements for work: _____

Current physical restrictions for work: _____

Native Language: _____ Language spoken most often: _____

CURRENT INJURY/PROBLEM

Date of injury/problem: _____ Work Related? Yes No

Chief complaint: _____

What caused your problem? _____

Previous Testing: MRI CAT X-Ray Other _____

Results of testing: _____

List any assistive or adaptive equipment/devices or supports you are currently using: _____

Related Complaints of Pain:

	<u>Constant</u>	<u>Intermittent</u>	<u>Improving</u>	<u>Unchanged</u>	<u>Worsening</u>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms	R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs	R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. Mark through the line below where you **pain is right now**

No Pain _____ **Extreme Pain**

2. Mark through the line below where you **pain** is when **at its worse**:

No Pain _____ **Extreme Pain**

3. Mark through the line below where you **pain** is when **at its best**:

No Pain _____ **Extreme Pain**

List all medications you are currently using (prescription and over the counter):

What makes/When is your pain better? (Check all that are appropriate)

- Bending Standing Walking Lying Down
- Stationary On the move Mornings Evenings
- Sitting Stand → Sit Sit → Stand As day progresses

What makes/When is your pain worse? (Check all that are appropriate)

- Bending Standing Walking Lying Down
- Stationary On the move Mornings Evenings
- Sitting Stand → Sit Sit → Stand As day progresses

Does the pain awake you at night? Yes No If yes, how frequently? _____

Do you have pain 24 hours/day? Yes No

Please give any other information you feel is important concerning your injury/problem: _____

GENERAL MEDICAL HISTORY

Please check yes or no to the following questions, and check whether it is related to your injury. This will help us understand your present and past medical history. This information will maximize the safety and effectiveness of your evaluation and/or treatment and is strictly confidential.

ALL PATIENTS:

- Do you have indigestion or heart burn? Yes No
- Do you have any heart problems or disease? Yes No
- Do you have a pacemaker? Yes No
- Do you have a heart murmur/heart valve problem? Yes No
- Do you have frequent or easy bruising or bleeding? Yes No
- Do you have high blood pressure? Yes No
- Have you had a stroke? Yes No
- Do you have diabetes? Yes No
- Do you have scoliosis? Yes No
- Do you have swelling in your arms or legs? Yes No Injury Related
- Do you have any fainting, dizziness, or light-headedness? Yes No Injury Related
- Do you have any nausea or vomiting? Yes No Injury Related
- Do you have any motion sickness? Yes No Injury Related
- Do you have epilepsy, a history of seizures, or convulsions? Yes No Injury Related
- Have you had changes in memory/orientation? Yes No Injury Related
- Do you have ringing in your ears? Yes No Injury Related
- Do you have any hearing problems/impairment? Yes No Injury Related
- Do you have visual problems or impairment? Yes No Injury Related
- Do you wear contacts, dentures, or hearing aids? Yes No Injury Related
- Do you have any difficulty swallowing? Yes No Injury Related
- Do you have any lung problems, breathing difficulty/disease? Yes No Injury Related
- Do you have bronchitis, asthma, emphysema, or COPD? Yes No Injury Related
- Are you awakened frequently at night? Yes No Injury Related
- Have you had any changes in your sleeping pattern? Yes No Injury Related
- Do you have unusual or frequent headaches? Yes No Injury Related
- Do you have extreme fatigue or loss of energy? Yes No Injury Related
- Have you had any increase in thirst or hunger? Yes No Injury Related
- Have you had any recent weight loss or weight gain? Yes No Injury Related
- How much? _____
- Have you ever had pain in your back? Yes No Injury Related

Surgical History: Check all that apply

- Back/neck surgery Bladder surgery Bowel/rectal surgery
- Gall bladder surgery Appendectomy Hernias
- Hemorrhoidectomy
- Other _____

Was your surgery injury related? Yes No

If you answered yes to the above list, please be specific with dates and outcomes.

Prior to your injury/problem did you exercise regularly? Yes No

Where? _____

How Often? _____

What exercises? _____

Are you currently exercising regularly? Yes No

Where? _____

How Often? _____

What exercises? _____

Have you ever had **any falls** (bike, skate board, ski, roller skating, etc.) or car accidents, list dates or age at time of injury and severity

DAILY FLUID INTAKE: (enter number of 8 oz cups/glasses of fluid taken daily)

- Water _____
- Caffeinated drinks (coffee, tea, colas, chocolate) _____
- Decaffeinated drinks (coffee, tea, colas) _____
- Alcohol _____
- Juices _____
- Other _____

BOWEL HABITS:

How often do you have a bowel movement? _____

Do you strain having a bowel movement? Yes No

Do you experience abdominal cramping? Yes No

Do you leak/stain feces? Yes No If yes, how often? _____

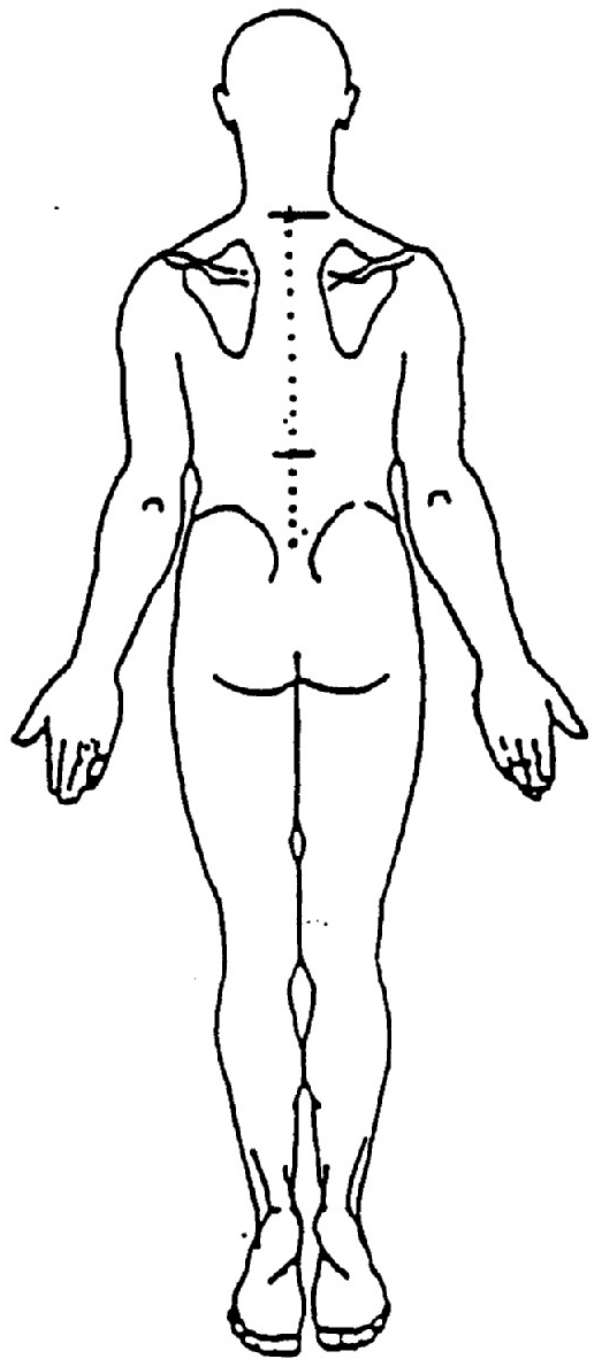
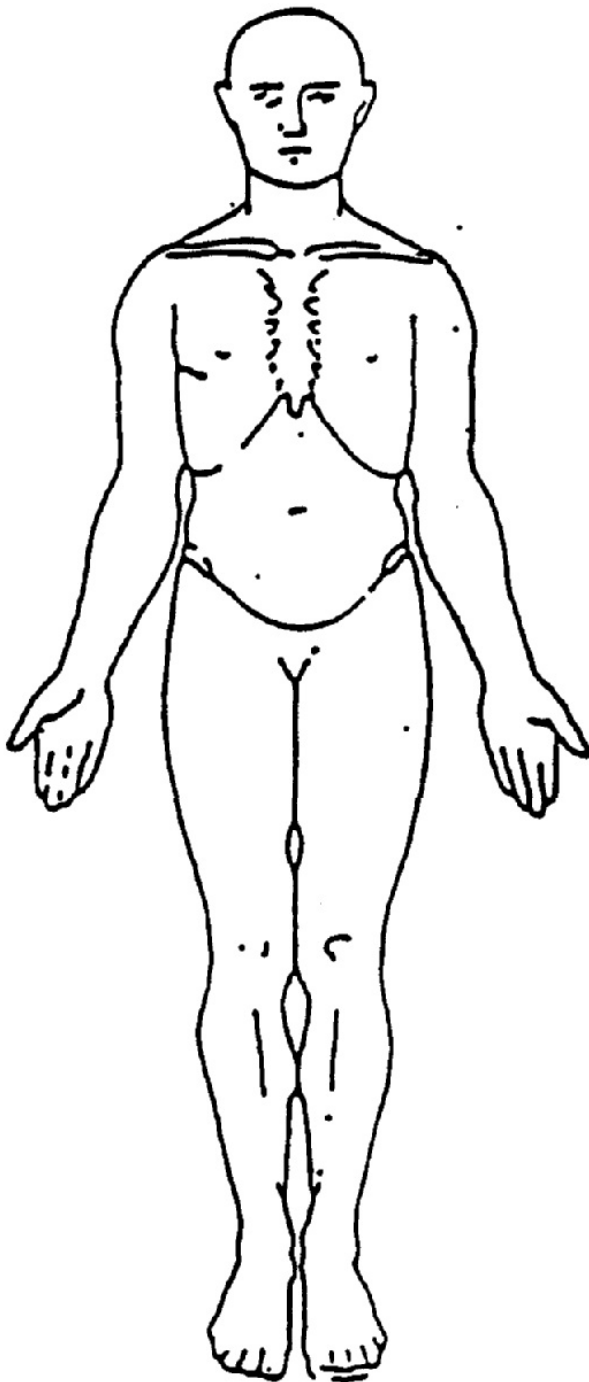
Do you experience diarrhea? Yes No If yes, How often? _____

Do you use laxatives? Yes No If yes, how often/week? _____

Do you use enemas? Yes No If yes, how often/week? _____

Do you include fiber in your diet daily? Yes No If yes, how much? _____

Please draw in where you are affected by your injury/problem.



Date: _____

There are many words that describe pain. The following is a list of words used to describe pain. Look at each work group and place a check (✓) by the **one** word in the section which best describes your present pain. Only indicate the words that describes your pain. You do not have to choose a word in every group. If none of the words in a particular group describe your pain, go to the next word group.

1.

- Flickering
- Quivering
- Pulsing
- Throbbing
- Beating
- Pounding

2.

- Jumping
- Flashing
- Shooting

3.

- Pricking
- Boring
- Drilling
- Stabbing

4.

- Sharp
- Cutting
- Lacerating

5.

- Pinching
- Pressing
- Gnawing
- Cramping
- Crushing

6.

- Tugging
- Pulling
- Wrenching

7.

- Hot
- Burning
- Scalding
- Searing

8.

- Tingling
- Itchy
- Smarting
- Stinging

9.

- Dull
- Sore
- Hurting
- Aching
- Heavy

10.

- Tender
- Taut
- Rasping
- Splitting

11.

- Tiring
- Exhausting

12.

- Sickening
- Suffocating

13.

- Fearful
- Frightful
- Terrifying

14.

- Punishing
- Grueling
- Cruel
- Vicious
- Killing

15.

- Wretched
- Blinding

16.

- Annoying
- Troublesome
- Miserable
- Intense
- Unbearable

17.

- Spreading
- Radiating
- Penetrating
- Piercing

18.

- Tight
- Numb
- Drawing
- Squeezing
- Tearing

19.

- Cool
- Cold
- Freezing

20.

- Nagging
- Nauseating
- Agonizing
- Dreadful
- Torturing

PRI (R) = _____

NWC = _____