Baldwin Bone and Joint Physical Therapy

1505 Daphne Ave.
Daphne, AL 36526
251-625-3178

Dear Patient:

Welcome to our office! We want to thank you for choosing Baldwin Bone and Joint for your physical therapy needs. We have a dedicated team of professionals who are available and committed to serving you. Our goal is to provide you with the highest quality services in a timely manner. Included in this packet are forms that need to be filled out by you. Please bring the completed paperwork to your appointment along with picture ID and your insurance card(s).

***** Please plan to arrive 15 minutes prior to your scheduled appointment time with your paperwork completed.**

A representative from our office will call you prior to the appointment to discuss your benefits as they relate to care in this office. If you need any additional assistance, please do not hesitate to call.

No Show/Cancellation Policy:

Your appointment time is reserved for you, by you. We appreciate 24-hour notice of cancellation. This enables us to offer the appointment to others. You may lose future scheduled appointments if you do not show for 3 consecutive appointments. We appreciate your consideration of others. I have read and understand the above policy.

Patient/Guardian Signature: ____ **Date:** ______________________

Informed Consent for Physical Therapy Services

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Baldwin Bone and Joint Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the intervention(s) will help resolve the condition for which you are seeking treatment.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Patient/Guardian Signature: ____ **Date:** ______________________

Baldwin Bone and Joint

Physical Therapy Questionnaire

Name: ____ **Date:** ______/______/______

DOB: ______/_______/_______ **Height:** ______________ **Weight:** _____________

Are you currently working? Yes/No **Retired?** Yes/No

Employer: ________________________ **Occupation:** _________________________

Disabled? Yes/No **If yes, reason for disability:** ______________________________

Have you received any Physical/Occupational/Speech Therapy this year? Yes/No

Have you received any home health services in the past month? Yes/No

Are you currently receiving home health services, including therapy, nursing, or aid services? Yes/No

Have you had any falls in the past 12 months? Yes/No

If yes, how many? ___________________________

If yes, did you receive an injury as a result of fall(s)? Yes/No

If yes, please explain____

Part of body being treated: ____

When did this problem begin? ________________ **Was this the result of an injury?** Yes/No

How did this problem begin? ____

Have you received any of the following for this problem? (Circle all that apply)

Epidural Medication Exercise Physical Therapy

Chiropractic Bracing Surgery Other:____________________________

Have you had any of the following for this problem: (Circle all that apply)

MRI CT Scan X-ray NCV Injection Other:____________________

List any prescription and over-the-counter medications that you are currently taking (provide copy of list if available):

____

____

____

Do you have a history of any of the following: (Circle all that apply)

Diabetes	Gout	Dizziness/Fainting
Heart Problems	High Blood Pressure	Joint Injuries
Pacemaker	Arthritis	Stroke
Liver/Kidney Disease	Seizures	Asthma
Thyroid Disease	Cancer	Osteoporosis

Have you been diagnosed with depression by a doctor? Yes / No

Have you been diagnosed with bipolar disorder by a doctor? Yes / No

Please list past surgeries:____

Other Medical History: ____

Any allergies (including drug allergies, latex or tape allergies). Please explain:

____

Please indicate your pain rating on the scale below (rate 1 to 10):

0____1_____2_____3_____4_____5_____6_____7_____8_____9____10

No Pain Moderate Pain Extreme Agony

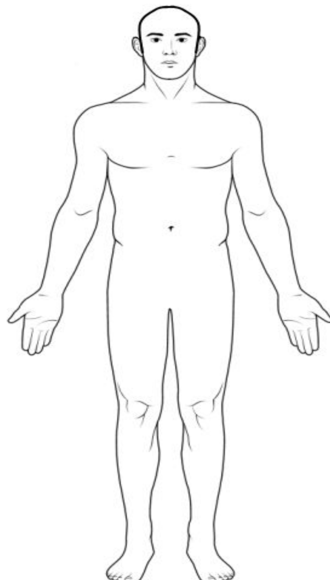
Circle any of the following that describes your pain:

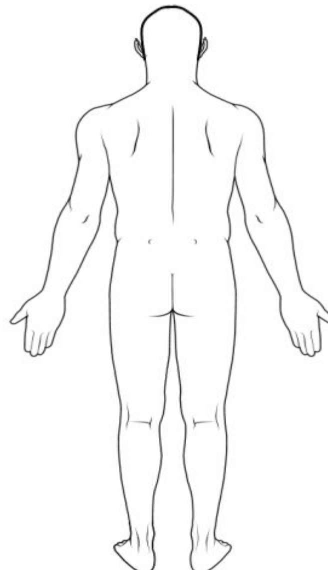
Sharp	Dull	Burning	Aching	Tingling
Numb	Constant	Variable	Radiating	Shooting

What makes your pain better? ____

What makes your pain worse? ____

Please indicate painful areas for current problem by shading the diagrams below:





Baldwin Bone and Joint PT Email Agreement

Baldwin Bone & Joint always strives to provide the highest quality service. Your opinion matters and allows us to refine what we do and how we do it. To continue to deliver the highest quality care available we would like to send you a survey to get your feedback. In addition, we may send you copies of your home exercise program (HEP) via email. If you would like to receive emails from our department please fill in the below.

- ○ I would like to receive surveys and home exercises by email
- ○ I DO NOT want to receive emails

Patient Name:____

Email address:____