

**Patient Information & Consent Form for Discovery Visit
Welcome to Active Fitness & Physical Therapy.**

Please fill this form out as completely as possible.

Name: _____ I prefer to be called: _____ Today's Date: _____

DOB: ___/___/___ Age: _____ Social Security #: _____

Home Address: _____ City _____ State _____ Zip _____

Home Phone #: () _____ Cell #: _____

Employer: _____ How Long There? _____ Occupation: _____

E-mail address: _____ Driver's License #: _____

MEDICALLY INFORMED CONSENT

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. Treatment may include Manual Therapy, Massage Therapy, Dry Needling, Therapeutic Exercise Programs and Modalities such as Electrical Stimulation, Ultrasound Class IV laser as well as diagnostic testing including Musculoskeletal Ultrasound and EMG/NCS. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at Active Recovery Physical Therapy. It is the clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from our services. Therefore, if "hands-on" manual or exercise techniques that are being used to retrain, recruit and restore normal function are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them. This consent shall be ongoing for a period not to exceed one year.

I (or _____ for _____) have read this form and fully understand and accept its terms and conditions.

Patient signature or Person Authorized to consent for Patient

Date

Relationship if signer for patient

Witness Signature

Describe why you are here. This will help the PT determine the underlying cause of your pain:

Where is your pain/problem? : _____

Pain Description: (Circle all that apply) Sharp Achy Numb/Tingling Constant Intermittent
WORST your pain has been in the past week? (0 = no pain, 10 = worst pain) _____

What aggravates/causes your pain? Sitting? Bending? Walking? What movements or activities?