First-Time Form Patient Information.

Items marked with asterisk (*) must be completed.

1. Patient Information

Items marked with asterisk (*) must be completed.

-Name *

First Name

Last Name

-Address *

Street *

City *

State *

Zip Code *

Email

Home #

Home Number

Work #

Work Number

Cell Number # *

DOB *

SS#

Social Security Number

Gender*: Patient is a* * -Male -Female -Other

1.1. Emergency Contact

Items marked with asterisk (*) must be completed.

-Name *

First Name

Last Name

-Relationship *

Relationship *

Phone*

1.2. Physician´s Info

Physician Name
Physician Name

Physician Phone
Physician Phone Number

Diagnosis
Diagnosis of Body Part

Sport / Activity
Sport / Activity

Concussion?

YES NO

Injured during sport?

YES NO

Have you seen a Chiropractor, Acupuncturist or had Physician Therapy for this injury somewhere else?

YES NO

 # Visits
Number of Visits

Physician Name (If no referring Physician select N/A)

YES NO NA

Sign *

_____

2. Health Questionnaire Form

Check the following that apply

1. Fevers/chills/sweats? *

YES *NO*

2. Unexplained weight loss/gain *

YES *NO*

3. Malaise (feeling generally unwell) *

YES *NO*

4. Unusual fatigue *

YES *NO*

5. Nausea/vomiting *

YES *NO*

6. Numbness/tingling *

YES *NO*

7. Weakness *

YES *NO*

8. Dizziness/lightheadedness/loss of consciousness *

YES *NO*

9. Chest pain/palpitations *

YES *NO*

10. Swelling in feet/hands *

YES *NO*

11. Difficulty breathing/shortness of breath *

YES *NO*

12. Difficulty breathing when lying down *

YES *NO*

13. Cough/change in cough/blood in phlegm *

YES *NO*

14. Wheezing *

YES *NO*

15. Difficulty swallowing *

YES *NO*

16. Heartburn/Indigestion *

YES *NO*

17. Change in appetite *

YES *NO*

18. Specific food intolerance/nausea/vomiting *

YES *NO*

19. Bowel pattern changes (color/texture/frequency) *

YES *NO*

20. Difficulty urinating (starting/stopping *

YES *NO*

21. Urine frequency changes *

YES *NO*

22. Name all diagnosed medical conditions and surgeries either existing or in the past:
Type here…

Please check if you have the following conditions:

23. Diabetes *

YES *NO*

24. High Blood Pressure *

YES *NO*

25. Osteporosis *

YES *NO*

26. Cancer/or History of Cancer *

YES *NO*

27. Pacemaker *

YES *NO*

28. Osteopenia *

YES *NO*

29. Stroke *

YES *NO*

30. Heart Condition *

YES *NO*

31. Pregnancy *

YES *NO*

32. Asthma *

YES *NO*

Please list any medications you are taking:

Please list any allergies.
Type here…

33. Are you allergic to: Latex? *

YES *NO*

34. Tape adhesive? *

YES *NO*

Sign or initials *

3. Sean Hampton MPT Policies

Please read carefully Items marked with asterisk (*) must be completed

1. **CONSENT**: I hereby request and consent Sean Hampton of Sean Hampton Global Physical Therapy Corp to provide my physical therapy treatments and other procedures within the scope of physical therapy. *

I Agree Intials_____

2. **AWKNOWLEGMENT OF RIGHTS**: 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 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 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 Agree Intials_____

3. **PRIVACY PRACTICES POLICY**: The terms of this Notice of Privacy Practices apply to Sean Hampton Global Physical Therapy's employees and each of its subsidiaries, affiliates, and entities. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. This provides information about how we may use and disclose protected health information about you. We may share your health information with those you authorize whom will be assisting you with your treatment or payment. We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We may be required to disclose to Law Enforcement, Federal officials, or military authorities health information necessary to complete an investigation. Other than what is stated about or where Federal, State, or Local law requires us, we will not disclose your health information without your written authorization. You have the right to request restrictions on certain uses and disclosures of your health information. You have the right to request that we communicate with you in a certain way. You have the right to read, review, and obtain a copy your health information, including your complete file of medical and billing records with a completed records request form and payment. You have the right to ask us to update or modify your records if you believe your health records are incorrect or incomplete. You have the right to ask for a description of how and where your health information was used by us for any reason other than for treatment, payment or health care operations. You have the right to obtain a copy of this Notice of Privacy Practices directly from us at any time. You have the right to express complaints to us, or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. A copy of any revised Notice of Privacy Practices or information may be obtained via Email. *

I Agree Intials_____

4. **PAYMENT POLICY**: Payment is due at the date and time of service provided. I hereby authorize my credit card on file to be used for services rendered. *

I Agree Intials_____

5. **CHECK RETURN POLICY (NSF):** In the event that the bank returns your check as non-sufficient fund, our office will automatically charge $25.00 to your account per attempt / per check, in addition to the amount due for the services rendered. *

I Agree Intials_____

6. SUPERBILL REQUEST: While we cannot bill your insurance directly, we can provide you a Superbill for you to submit to insurance yourself with a current referral from your Medical Doctor. Please let us know if you'd like us to provide you a Superbill? *

Yes *No*

7. APPOINTMENT REMINDER: Our office provides an automatic courtesy reminder call/text/email the day before your appointment. If you wish to decline this offer, please contact my assistant. *

I Agree Intials_____

8. NO SHOW & CANCELLATION POLICY: Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment time, you must cancel at least 24 hours in advance Monday-Friday during our business hours 8:00 am to 5:00pm via phone, text, or email. There will be a charge for No Show or Cancellation appointments with less than 24-hours' notification. Fees are as follows: $200 (office visit) $350 (home visits) per missed appointment. I acknowledge I will be personally responsible for any no show or late cancellation fees. *

I Agree Intials_____

9. I have read and fully understand the above-referenced policies and do hereby agree to comply as specified. *

I Agree Intials_____

Name *
First Name *Last Name*

Date *

Sign or initials * _____

Patient or Guardian Signature Witness (Office Staff) *A photocopy of this authorization will be considered as valid as the original. *

First Name *Last Name*

4. Nutrition Questionnaire

Select all that apply
Mark one or more options.

1) What are your top three health concerns?

Sleep
Immunity
Specific condition
Fitness
Joint Support
Digestive disorders
Mood
Energy
Heart
Inflammation
Fatigue

2) Do you currently follow any of these specific diets?

Paleo
Pescatarian
Vegan
Vegetarian
Ketogenic
None

Other

3) Do you have any of the following skin conditions?

Eczema
Psoriasis
Acne
Rosacea
Skin Rash
None

4) Do you frequently have any of these digestive problems?

Bloating
Diarrhea
Constipation
Food allergies
IBS
Acid reflux or heartburn
Abdominal pain
None

5) How is your mood and stress level?

I am stressed all the time.

I´ve recently experienced a stressful event (e.g. loss, divorce).

I often feel fatigued, and unable to focus.

I would like to improve my mood.

I have no complaints

6) On average, how do you sleep?

I don’t sleep well

My sleep is interrupted (snoring, waking up to urinate)

When I try to sleep, my mind often races

Other reason

7) Do you have any bone health issues or concerns?

Bone density

Osteoporosis

Osteogenesis imperfecta

Osteoarthritis

Paget's disease

Scoliosis

Low bone density

Gout

None of the above

8) Please list all supplements you are currently taking (e.g. fish oil, herbs)
Type here…

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8) Please list all supplements you are currently taking (e.g. fish oil, herbs)
Type here…

9) Are you currently concerned about your weight?

YES *NO*

Sign or initials.

_____

5. COVID-19 Questionnaire

1. Have you had recent contact with anyone who tested positive for COVID-19, or any other communicable diseases? *

YES *NO*

2. A cough *

YES *NO*

3. Fever over 99.6 degrees? *

YES *NO*

4. Shortness of breath and/or trouble breathing? *

YES *NO*

5. Recent loss of taste or smell? *

YES *NO*

6. Diarrhea? *

YES *NO*

Sign or initials.

_____