Sherwood Crossing
7910 Andrus Road, Suite 5
Alexandria, VA 22306
Phone: (571) 481-4547
Fax: (571) 551-6419

MOUNT VERNON
PHYSICAL THERAPY

PATIENT INFORMATION
(Address and DOB maybe left blank if it matches photo ID)

Last Name:		First Name:
Address:		
City:	State:	Zip:
Home Phone: ☐ Primary	Cell Phone: ☐ Primary	Work Phone: ☐ Primary
DOB:	Email:	

How did you hear about us? (circle one please) MD Insurance Friend Internet Other:

Referring Doctor (MD): ____ Next scheduled MD appt: ______________________

Have you had any prior Physical Therapy/Occupational/Speech Therapy this calendar year?

☐ No

☐ Yes, Dates of treatment: ____

Do you have an ongoing 3rd party litigation for this condition?

☐ No

☐ Yes (circle one please) Employment Automobile Accident

PRIMARY INSURANCE ***(only complete if you are <u>not</u> insurance subscriber)***	**SECONDARY INSURANCE** ***(only complete if you are <u>not</u> insurance subscriber)***
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Relation to Patient:	Relation to Patient:

EMERGENCY CONTACT

Last Name:	First Name:
Phone:	Relationship:

APPOINTMENT REMINDER CONSENT (choose one only)

☐ Mount Vernon Physical Therapy may send me cell phone text messages to confirm my appointments to: _________________________ **(I recognize that normal text messaging rates may apply)**

☐ Mount Vernon Physical Therapy may send me automated voice call reminders to: ______________________________

☐ Mount Vernon Physical Therapy may send me automated email reminders to: ______________________________

Turn Over

MEDICAL SCREENING

PAIN SCALE LAST 48 HOURS											
Where is your pain?											
Describe your pain?											
Worst level of pain (Please circle)	0	1	2	3	4	5	6	7	8	9	10
Current level of pain (Please circle)	0	1	2	3	4	5	6	7	8	9	10
Best level of pain (Please circle)	0	1	2	3	4	5	6	7	8	9	10

Do you feel emotionally and physically safe at home/work?____

Do you have worrying thoughts going through your mind a lot of the time? ____

FALL RISK INTAKE

Have you fallen in the past year? ☐ No ☐ Yes, date(s): ____

PAST MEDICAL HISTORY

Are you currently, or have you previously been, diagnosed with any of the following (please check **all** that apply):

- ☐ Stroke
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Atrial Fibrillation
- ☐ Surgeries____________
  ____
  ____
  ____
  ____
- ☐ Diabetes Type I Type II (circle type)
- ☐ History of Fracture,
  Location______________
  ____
- ☐ Shoulder Problems
- ☐ High Blood Pressure
- ☐ Infection
- ☐ Cancer, Location_____
  ____
- ☐ Arthritis
- ☐ Joint Replacement,
  location__________________
  ____
  ____
- ☐ Thyroid Disorder
- ☐ Muscular Dystrophy
- ☐ Other___________________

Have you had any tests done related to your symptoms? ☐ MRI ☐ X-Ray ☐ CT Scan ☐ Ultrasound ☐ Blood Test

Medication, Vitamins & Supplements

Please list all medications including **frequency** and **dosage** (both over-the-counter and prescribed):

Name	Dosage	Frequency	Route of Administration (Circle one)			
			Oral	Sublingual	Topical	Subcutaneous Injections
			Oral	Sublingual	Topical	Subcutaneous Injections
			Oral	Sublingual	Topical	Subcutaneous Injections
			Oral	Sublingual	Topical	Subcutaneous Injections
			Oral	Sublingual	Topical	Subcutaneous Injections
			Oral	Sublingual	Topical	Subcutaneous Injections
			Oral	Sublingual	Topical	Subcutaneous Injections

Mount Vernon Physical Therapy

Review of Financial Policy

Mount Vernon Physical Therapy believes a clear understanding of our Financial Policy is essential to our professional relationship. If you have any questions or concerns, please do not hesitate to ask a member of our staff for clarification.

- ☐ I have fully read, understand, and agree to comply with the terms of the Mount Vernon Physical Therapy Financial Policy.

Review of Notice of Privacy Practices

- ☐ I acknowledge that I have received a copy of Mount Vernon Physical Therapy's Notice of Privacy Practices.

Review of 24-Hour Cancellation and No-Show Policy

- ☐ I acknowledge that I have received a copy of Mount Vernon Physical Therapy's 24-Hour Cancellation and No-Show Policy

By signing below, you acknowledge that you have received these notices, understand the policies and agree to the terms.

Patient Name: ____

Patient Signature: ____ Date: ______________________

Legal Guardian Signature: _________________________________ Date: ______________________

Medical Records Release (optional)

I give authorization to the following individuals to review or receive my Protected Health Information (PHI). I understand that this authorization remains in effect until specifically rescinded by me in writing.

Name: ____Relationship: _________________________________

Name: ____Relationship: _________________________________

Patient/Legal Guardian Signature: ______________________________________Date: ___________________