Patient Information

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Height:_____ Weight:_____

Employer: _____ Referred by: _____

Emergency Contact: _____ Phone: _____

TheraPilates® Physical Therapy
WAIVER OF LIABILITY, CANCELLATION POLICY & INFORMED CONSENT RELEASE:

I have enrolled in a program of instruction in the Pilates Method, Yoga or Physical Therapy offered by TheraPilates® Physical Therapy.

I have been informed and acknowledge that TheraPilates® Physical Therapy makes no claims as guaranteed results which can or may be obtained through participation in this program onsite or online. or use of any Pilates, or TheraPilates® Physical Therapy equipment.

If there are any activities that a physician or other chosen healthcare practitioner has advised against doing, I agree to inform the instructor or Physical Therapist before beginning this program and for the duration of the program. The physician in charge of my care either agrees or has recommended that I participate in programs offered by TheraPilates® Physical Therapy. I will keep TheraPilates® Physical Therapy fully informed of any physical or medical conditions or disabilities or changes in my status throughout the course of treatment or instruction which would prevent or limit participation in this program of instruction or use of equipment.

I realize that there is unavoidable risk of injury, especially if I have a pre-existing injury, illness or medical disability and have informed TheraPilates® of any such pre-existing condition. I understand that a medical evaluation is advisable before beginning any program of exercise. I understand that use of exercise equipment also carries with it a risk of injury. I recognize that many changes may occur as a result of these exercise lessons and treatment, including possible short-term aggravation of some symptoms, feelings of tiredness, lightheadedness, increased or decreased energy, nausea, mood changes, etc. and that any strenuous athletic or physical activity involves risk of injury.

I assume the risk of any and all accidents or injuries of any kind which may be sustained by reason of or in connection with use of its directors, shareholders, employees, apprentices, student teachers, and contractors from any and all claims, demands, rights of action, present or future, whether known or unknown resulting from participation in this program of instruction or use of TheraPilates® Physical Therapy facilities or equipment. I expressly assume all risks of injuries resulting from my participation in this program of instruction and use of TheraPilates® Clinic, facilities or equipment.

INFORMED CONSENT for ONSITE OR TELEHEALTH PHYSICAL THERAPY SESSIONS:

1. I have presented myself in-person or through online platforms for physical therapy treatment and consent to the examination, treatment and exercise programs that will be provided by the physical therapist. I understand that my diagnosis & treatment plan will be discussed and that I have the right to question and/or refuse any treatment offered.
2. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.
3. I authorize the release of medical information only as necessary to provide my physical therapy treatment.
4. I understand that I should refrain from the use of perfumes, colognes or scented skin care products as they can be a cause for allergic reactions in others during onsite visits.
5. I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am authorizing persons listed on the Information Release to receive my health information.

I understand that by enrolling in Pilates or Exercise Sessions that it is for personal use only and agree not to teach Pilates Exercise in any form. Any handouts given are copyrighted material and will not be distributed, duplicated or sold by any means. I am aware that only fully certified and licensed teachers are authorized to teach the Pilates Method of exercise.

TheraPilates® Physical Therapy shall not be responsible for any article lost, stolen or damaged in or about the clinic.

CANCELLATIONS must be received 24 hours in advance to be granted a make-up session. The session is forfeited if less than 24 hours notice is given.
TheraPilates® Physical Therapy policy is that no refunds are given-but special cases are considered. Please cancel any appointments or classes at least 24 hours in advance to avoid paying the full fee for your session. Thank you very much for your courtesy in letting teachers know that you are canceling your appointment in advance of your session.

For our onsite studio:
□ Please no perfumes due to others with allergic sensitivity.
□ Avoid using body lotions prior to your sessions since they make the equipment slippery and hazardous.
□ I realize that this is a teaching facility and that sessions may be observed by students in training.

I have read the above liability waiver and agree to the terms and conditions stated above.

Patient/Client (or Guardian) Name:_____

Patient/Client (or Guardian) Signature:_____

Date Signed: _____

PHYSICAL THERAPY PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____ Time In: _____Out: _____

Gender:_____ DOB: _____ Age: _____ ID#_____

Occupation: _____ Are you currently working: Yes / No

What percent of your workday do you sit? _____ Stand? _____ Living Arrangement: _____

Are you or could you be pregnant? Yes / No Steps to enter home:_____ Handrail:_____Steps Inside home:_____ Handrail:_____

Have you had a fall in the past 5 years? If yes, please explain:_____

Have you smoked tobacco or cannabis in the past? Yes/No Currently? Yes/No # of Cigarettes per day: _____

Impairments: Visual, Hearing, Speech, Walking, Endurance, Short of Breath, Contractures/Stiffness, Amputations, Seizures, Allergies

(circle any that apply and add additional: _____

Past Medical History

Have you ever been told that you have or had (circle Yes or No):

Cancer	Yes	No	Pacemaker	Yes	No	Seizures	Yes	No
Diabetes I or II	Yes	No	Heart Disease	Yes	No	Lung Disease (COPD)	Yes	No
Stroke	Yes	No	Kidney Disease	Yes	No	High Blood Pressure	Yes	No
Ulcers	Yes	No	Liver Disease	Yes	No	Rheumatoid Arthritis	Yes	No
Blood Clot	Yes	No	Osteoporosis	Yes	No	Hepatitis (A, B or C)	Yes	No
Allergies	Yes	No	Fibromyalgia	Yes	No	Broken Bone	Yes	No
Asthma	Yes	No	Angina/Chest Pain	Yes	No	Vascular Disease	Yes	No

Other _____

In the past 3 months, have you experienced any of the following?:

Dizziness	Yes	No	Change in appetite	Yes	No	Shortness of Breath	Yes	No
Headaches	Yes	No	Pain with meals	Yes	No	Unexplained weight loss	Yes	No
Depression	Yes	No	Fever/chills/sweats	Yes	No	Pain w/ coughing/sneezing	Yes	No
Nausea/vomiting	Yes	No	Difficulty swallowing	Yes	No	Bowel/Bladder Changes	Yes	No
Falls/poor balance	Yes	No	Increased pain at night	Yes	No	Unusual Menstrual Pain	Yes	No
Chest Pain	Yes	No	Numbness/Tingling	Yes	No	Recent Infection	Yes	No
Abdominal Pain	Yes	No						

Other Symptom: _____

Past Injuries, Traumatic Accidents, Motor Vehicle Accidents an Surgical History (include dates): _____

_____

_____

Current Medications (current list can be given to front desk to copy instead of writing here):

_____

_____

Preferred spoken language: _____ Visually impaired? Yes / No Hearing impaired? Yes / No

CONSENT: I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

Signature: _____ Date: _____

Primary Complaint

What date (approximately) did your present problem/symptoms start? _____

How (gradually, suddenly, injury)? _____

Are your symptoms currently (circle one): Getting better / About the same / Getting worse

What treatments have you received for this problem so far? _____

_____

What makes your symptoms better? _____

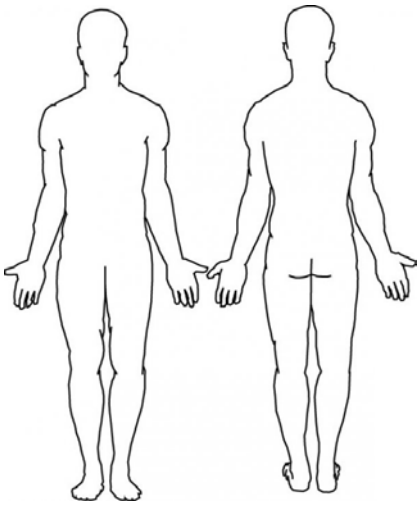
What makes your symptoms worse? _____

Have you had bloodwork, an x-ray, MRI or other imaging study for this problem? Yes / No

If yes, where were they taken? _____

Have you had similar symptoms in the past? Yes / No What treatments did you receive? _____

Body Diagram: Please mark the areas where you feel pain on the chart below:



Ache
Shooting pain
Pins & needles
Sharp Pain
Numbness & tingling

Please mark the type and location of your pain on these pictures.

Pain Scale: On this scale from 0-10, please circle the number which best represents your pain:

At best, my pain is:	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
At worst, my pain is:	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
Currently my pain is:	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable

Please circle the number below which best represents your overall average level of function:

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 Able to everything

How are you able to sleep at night (circle)? Fine Moderate difficulty Only with Medication

Do you exercise? Yes / No Days per week? 1 2 3 4 5 6 7 Type of Exercise:_____

Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem:

1. _____
2. _____
3. _____

What are your personal goals for therapy at this time? _____

_____