Thank you for choosing Resilient Physical Therapy and Wellness, LLC! Please fill out the following forms completely and to the best of your knowledge. This information will help us to better serve you. All information will remain private and confidential.

PATIENT NAME:	
DOB:	**SEX:** MALE FEMALE
ADDRESS:	**PHONE:** May we text this number with urgent appointment changes? YES NO
EMAIL:	

REFERRING PHYSICIAN (IF APPLICABLE):
INSURANCE PROVIDER:

EMERGENCY CONTACT:	**PHONE:**
RELATIONSHIP TO PATIENT:	

CONSENT TO TREAT

I voluntarily authorize Resilient Physical Therapy and Wellness, LLC to perform outpatient diagnostic evaluation(s) and/or procedure(s) and to administer such outpatient therapy that is necessary. I understand that outpatient therapy is not an exact science and no guarantee has been made as to the result of any treatment or care administered.

PATIENT INITIALS:

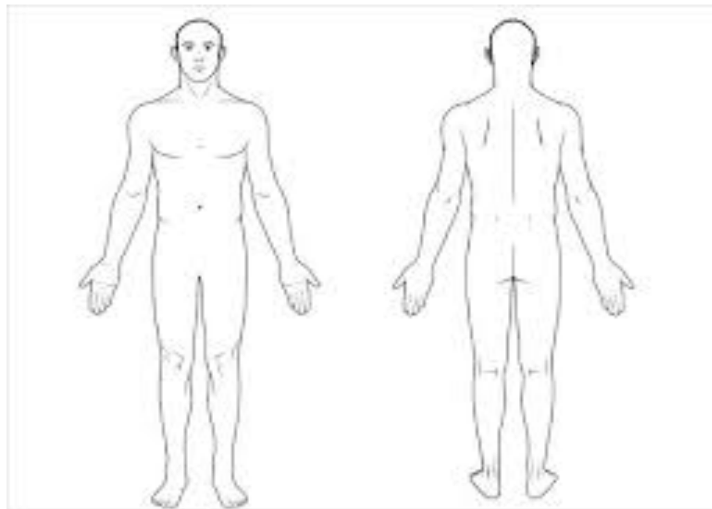
PAYMENT POLICY

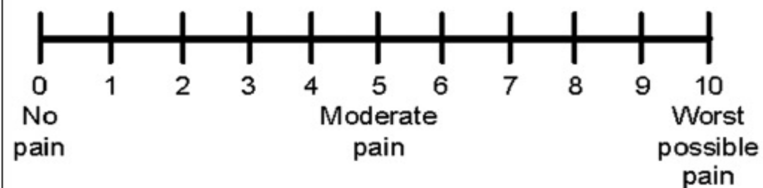
I understand that payment is expected on the day of each session or paid in advance. I am responsible for all charges, regardless of insurance coverage. I understand that **Resilient Physical Therapy and Wellness, LLC** is not a Medicaid or Medicare Provider and, therefore, cannot submit payment for reimbursement. I understand that prompt payment is expected for services and I agree to pay for services as expected.

PATIENT INITIALS:

BRIEFLY DESCRIBE YOUR CURRENT INJURY:
DATE OF ONSET:
PROVIDERS SEEN FOR THIS INJURY:
IMAGING (X-RAY, MRI, ETC):

PLEASE CIRCLE WHERE YOUR PAIN IS LOCATED:





CURRENT MEDICATIONS:
SURGICAL HISTORY (PLEASE INCLUDE DATES):

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE)

Pacemaker	Anemia	Asthma
Metal Implants	Fracture	Shortness of Breath
High Blood Pressure	Arthritis	Chronic Cough
Diabetes	Osteopenia	Fainting Spells
Heart Disease	Osteoporosis	Hernia
Heart Attack	Cancer/Tumor	Skin Conditions
Vascular Disease	Recent Weight Loss or Gain	Headaches
Stroke	Current Infections	Head Injury/Concussion
Deep Vein Thrombosis (DVT)	Bowel or Bladder Problems	Thyroid Problems

PLEASE USE THIS SPACE TO LIST ANY ADDITIONAL CONDITIONS NOT LISTED ABOVE.

IS THERE ANYTHING ELSE YOU FEEL WE SHOULD KNOW REGARDING YOUR MEDICAL HISTORY?

IF YOU HAVE A TYPICAL EXERCISE ROUTINE, PLEASE DESCRIBE IT HERE.

CANCELLATION POLICY

Please allow 24 hours advance notice for appointment changes or cancellations.
Cancellations made within 24 hours of the appointment will be charged a **$50** late cancellation fee.
Note: We do not charge cancellation fees for illness-related cancellations or emergencies.
If the therapist is running late, the client will receive their full treatment time. When the client is late for the session, the client incurs the loss of time and payment for the full session is expected.

I HAVE REVIEWED AND COMPLETED THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: **DATE:**