Admission Record

Form Completion Instructions:

Please answer all fields (Please enter N/A if not applicable). All information will remain strictly confidential. Questions, please ask our office associate.

Client Name:			Client Date of Birth	Social Security Number __ __ __ - __ __ - __ __ __ __
Mailing Address (No. & Street, Apt., etc.)			E-Mail Address (Required)	
City	State	Zip Code	Cell Phone Number ( )	
Home Phone Number ( )	Work Phone Number ( )		Preferred Phone Contact ☐ Cell ☐ Home ☐ Work	
Primary Insurance Carrier Name			Secondary Insurance Carrier Name	
Insured's relationship to you ☐ Self ☐ Parent ☐ Spouse ☐ Other			Insured's Name (Who carries insurance contract)	
Insured's Employer Name:			Insured's Employer Address:	
City	State	Zip	Employer Phone Number:	
Insured's Date Of Birth:			Emergency Contact and Phone	
Is this injury from a Motor Vehicle Accident? ☐ Yes ☐ No			Is this injury from a Workmans Comp. claim? ☐ Yes ☐ No	
If yes, what is the name of the claims adjuster?			If yes, what is the phone number of the claims adjuster?	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed			Your occupation:	
Spouses Name:			Spouses Date of Birth	Social Security Number
PRIMARY CARE Physician Name			Phone Number	Date of Next Office Visit
REFERRING Physician Name (If any)			Phone Number	Date of Next Office Visit

Select all that apply: *"I'm coming to Borja Physical Therapy now because of…"*

☐ Friend/Family Member ☐ Online Search ☐ Valpak ☐ Radio ☐ Report
☐ My Doctor/Health Provider ☐ Facebook ☐ Google ☐ Newsletter ☐ Workshop
☐ My Insurance Website ☐ Newspaper ☐ Local Network ☐ Saw Sign ☐ Other: _____

Client Authorization And Responsibility

I hereby consent to treatment at Borja Physical Therapy PLLC. By consenting to treatment I authorize, on behalf of any covered family member or myself, direct billing of my insurance company and direct payment to Borja Physical Therapy PLLC. By consenting to treatment, I also consent to the release of necessary medical

information needed for the processing of the insurance claims, including release to any entity for the continuation of my medical care. I understand that a photocopy of the release is as valid as the original. In the event that my insurance company does not pay or partially pays on behalf of any covered family member or myself, I understand that it is my financial responsibility to remit payment in full to Borja Physical Therapy PLLC upon completion of the treatment sessions or within 30 days thereafter. I further understand that if the matter is referred to an attorney for collection, I will be responsible for the attorney's fees and court costs.

Signature of Client/Guardian/Parent	**Date**

Missed Appointments Policy

At Borja Physical Therapy we currently do not charge a fee for missed appointments. While charging up to full value of the missed visit is a customary practice, we feel this is unfair to our clients. To keep our service "fee free" we only ask you notify us at least 24 hours in advance if you will be missing an appointment. After two cancellations, we reserve the right to require same day appointment reservations or discharge from therapy services altogether with non-compliance documentation. Please help us serve the community by keeping our premium physical therapy services free from missed appointment fees.

Signature of Client/Guardian/Parent	**Date**

Notice Of Privacy Practices

I hereby authorize that I am aware of my rights as it pertains to HIPAA and my Protected Health Information (PHI). Borja Physical Therapy has offered me a copy of their Notice of Privacy Practice for my own records. You may see our privacy practices at: borjapt.com/privacy-notice/ or request a copy from our Customer Service associate.

Signature of Client/Guardian/Parent	**Date**

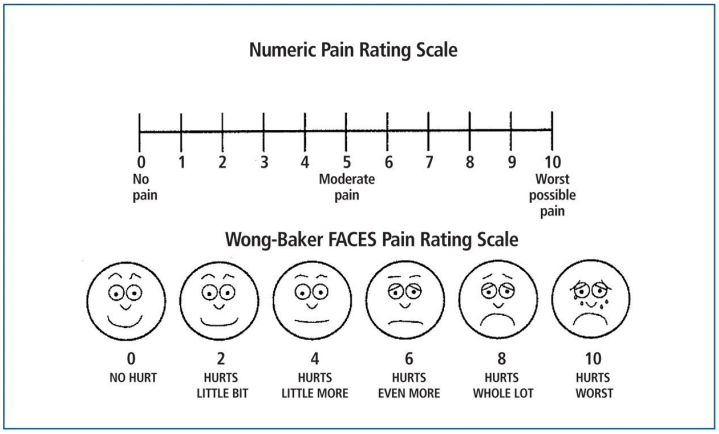
Medical History Information

Your Name _____ Your Age: _____

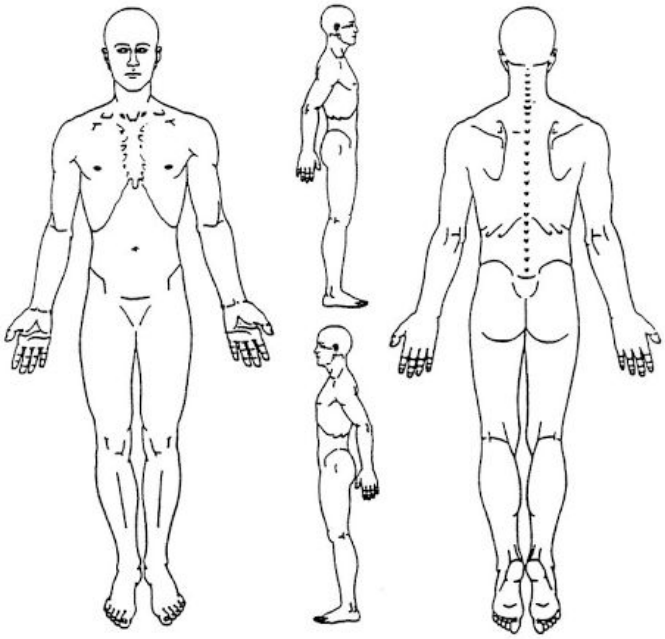
Use this chart to help you describe your particular level of pain to your health care provider.

☐ I have no pain ☐ Pinching ☐ Throbbing
☐ Stabbing ☐ Burning ☐ Persistent
☐ Dull ☐ Steady ☐ Comes & goes
☐ Aching ☐ Localized ☐ Pinching
☐ Other (please describe) _____

Use the chart below to assess your pain level:



Please shade or circle the areas where you are experiencing pain.



My pain at it's worst is:

0 1 2 3 4 5 6 7 8 9 10
(Circle one)

My pain on average is:

0 1 2 3 4 5 6 7 8 9 10
(Circle one)

1. What was the specific cause of injury, or the series of events leading up to your visit today?

Description: _____

_____

2. When were you injured? _____. Was your pain ☐ **Sudden** or ☐ **Gradual**?

3. Was your injury: ☐ Sudden or ☐ Gradual?

4. Medical History: Select all that apply to you. Have you been diagnosed with the following:

Arthritis/Osteoarthritis?	☐ Yes ☐ No	Diabetes Type 1?	☐ Yes ☐ No
Rheumatoid Arthritis?	☐ Yes ☐ No	Diabetes Type 2?	☐ Yes ☐ No
Osteoporosis?	☐ Yes ☐ No	Obese?	☐ Yes ☐ No
High blood pressure?	☐ Yes ☐ No	Seizures?	☐ Yes ☐ No
Heart/circulation disorders?	☐ Yes ☐ No	Dizzy Spells?	☐ Yes ☐ No
Immune deficiency disease?	☐ Yes ☐ No	History of Cancer?	☐ Yes ☐ No
History of falling?	☐ Yes ☐ No	Currently pregnant?	☐ Yes ☐ No
Hard of hearing?	☐ Yes ☐ No	Vision Difficulty?	☐ Yes ☐ No

Explain / Other not listed:

_____

_____

5. Imaging: Check all imaging performed for your condition:

☐ X-ray ☐ MRI ☐ CT Scan ☐ Other: _____ When?

_____

What were the results? _____

6. Surgery: Please list any and all surgeries you have had at or near your injury site and include year performed.

_____

7. **List medications you are taking now:** If you brought a list, we can make a copy. If no list today, please list below. We cannot see you without a list of medications today. Please include name, dosage and frequency.

_____

_____

8. List any allergies you have: _____

Name of person completing this form (print)	Signature of Client or Responsible Adult and Date

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Do NOT complete this section. This section to be completed by your physical therapy clinician.

Clinical Notes

ROM:			
Flexion:	_____°	Flexion:	_____°
Extension:	_____°	Extension:	_____°
Abduction:	_____°	Abduction:	_____°
Internal Rotation:	_____°	Internal Rotation:	_____°
External Rotation:	_____°	External Rotation:	_____°
Side Bend R:	_____°	Side Bend R:	_____°
Side Bend L:	_____°	Side Bend L:	_____°
Rotation R:	_____°	Rotation R:	_____°
Rotation L:	_____°	Rotation L:	_____°
MMT:			
Flexion:	_____ /5	Flexion:	_____ /5
Extension:	_____ /5	Extension:	_____ /5
Abduction:	_____ /5	Abduction:	_____ /5
Internal Rotation:	_____ /5	Internal Rotation:	_____ /5
External Rotation:	_____ /5	External Rotation:	_____ /5
Side Bend R:	_____ /5	Side Bend R:	_____ /5
Side Bend L:	_____ /5	Side Bend L:	_____ /5
Rotation R:	_____ /5	Rotation R:	_____ /5
Rotation L:	_____ /5	Rotation L:	_____ /5

Pain increases with: ☐ Passive ☐ Active ☐ Flexion ☐ Extension ☐ Rot. R ☐ Rot. L ☐ Other:

_____

Pain decreases with: ☐ Passive ☐ Active ☐ Flexion ☐ Extension ☐ Rot. R ☐ Rot. L ☐ Other:

_____

Special Testing

(+)(-)	(+)(-)	(+)(-)	(+)(-)

☐☐ SLR
☐☐ Fabers
☐☐ Piriformis sign
☐☐ Slump test
☐☐ Instability test

☐☐ Hip IR test
☐☐ Thomas test
☐☐ Patellar Tracking
☐☐ Excessive Q angle
☐☐ IT band syndrome

☐☐ Thessaly's Test
☐☐ ACL/PCL/MCL/LCL
☐☐ Lat Jt line
☐☐ Medial Jt line
☐☐ _____

☐☐ Hawkins-Kenney
☐☐ Impingement
☐☐ Biceps load test
☐☐ A/C compression
☐☐ _____