/

Kinect
PHYSICAL THERAPY & WELLNESS

Dear First Time Patient,

Welcome to the "Kinect" family and thank you for your interest and appointment with us. We look forward to entering with you into a positive and progressive Physical Therapy experience.

Enclosed you will find the necessary paper work that should be completed at the first visit and prior to your evaluation with the Physical Therapist. Please take this opportunity to fill in the paperwork to the best of your ability. Make sure to review each document and sign. Feel free to use our website at kinectphysicaltherapy.com for helpful information. When you arrive for Physical Therapy sessions (including first one), please wear comfortable clothing to be able to exercise in and to easily allow us access to your injury. It will be best to arrive 10-15 minutes before the first appointment (especially if there are any questions with paperwork). Anticipate for your appointments to be about 80 minutes for the first session, unless informed otherwise. Follow up sessions will be made at the end of the first session and are usually expected to be 50 min.

For your appointment please bring:

- Comfortable clothing
- A pair of most commonly worn shoes (for assessment)
- Payment
- Prescription for Physical Therapy in addition to helpful MD, X-ray, MRI and other comparable reports if available

- An open mind to learn something new about yourself.

We look forward to meeting you and working with you towards a positive Physical Therapy experience!

Sincerely,

Kinect Physical Therapy

Kinect
PHYSICAL THERAPY & WELLNESS

General Information:

Name: _____ ***Age:*** _____ ***DOB*** _____ ***Gender: M / F***

Address: _____ ***City:*** _____ ***State:*** _____ ***Zip:*** _____

Phone: _____ ***e-mail:*** _____

Spouse / Guardian name: _____ ***May we give them your medical information? Yes / No***

Emergency Contact: _____ ***Contact Phone:*** _____

Diagnosis: _____

Associated MD / health care practitioners in this case: _____

How did you hear about us? _____

Kinect Policies

1. **Cancellation/No Show/Late Notice:** A 50% fee will be charged for the following:
   - If you do not notify us 24 hours in advance to cancel your appointment
   - If you do not show to your scheduled appointment
   - If you are arrive late, the full appointment fee applies

2. **Payment:** The payment is due on each scheduled appointment day.

3. **Proper Clothing:** Please wear clothing that is appropriate for exercise and allows access to your injury.

4. **Cell Phones:** We request that you use your cell phone only for the benefit of your care. We ask that your cell phone is not a distraction to your treatment progression and poses no threat to other patients' privacy.

5. **Family and Friends:** If you have family and/or friends that accompany you, please make sure they are ready to be a valuable part of your healing experience.

6. **Home Exercise Program:** We often include a progressive home exercise / symptom management program as part of your treatment. All should agree that compliance with this process of your care allows for an acceleration towards your goals and quality of life.

Signature _____

Consent to Treat

I , _____ do hereby consent, authorize, and request Kinect Physical Therapy Inc. to administer such treatment as deemed advisable, necessary, or requested. I agree to hold Kinect Physical Therapy Inc. free and harmless from any claims, suits, damages or complications which may result from such treatment.

X_____ _____

Signature of Patient Date

Consent to Treat a Minor *(Fill out only if patient is under the age of 18)*:

I / We being the parent / legal guardian of _____ a minor age of __ do hereby consent, authorize, and request Kinect Physical Therapy Inc. to administer such treatment as deemed advisable, necessary, or requested for the above named minor. I / we agree to hold Kinect Physical Therapy Inc. free and harmless from any claims, suits, damages or complications which may result from such treatment.

X_____ _____

Signature of Parent / Legal guardian Date

Notice of Privacy Practices - Consent Form:

By my Signature below, I acknowledge that I have been given the opportunity to review the ***Notice of Privacy Practices*** for Kinect Physical Therapy.

(The notice is available for viewing on our website at kinectphysicaltherapy.com, and / or for you to take / view in paper form at our front desk).

X _____

Signature of Patient

Email Policy

Please know that as you become a part of the Kinect family, you will on occasion receive emails from our office based on our findings and your needs. This may include prescribed exercises, updates on clinic offerings or information we want to share with our valuable patients. We will not share your email at any time with anyone without your consent, and we will never sell your information or data. Please refer to the privacy policy for more information.

PHYSICAL THERAPY & WELLNESS

Health Questionnaire

Please Fill Out Completely **Date:**_____

Name_____ **Age**_____ **DOB**_____

When did your injury / condition occur? _____, Did it begin ◯ immediately or ◯ gradually.

How did it occur?_____

_____

What body parts were initially painful or affected?_____

_____

What body parts are currently painful or affected? _____

_____

Since this condition / injury began, are your symptoms: ◯ Increasing ◯ Decreasing ◯ No change.

How often do you feel your symptoms?
◯ Occasional (10-25%) ◯ Intermittent (26-50%) ◯ Frequent (51-80%) ◯ Constant (90-100%)

If you have pain, please mark your pain on the scale below. "0" is no pain, "10" is worst pain ever.
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Choose what most accurately describes your symptoms.
◯ Symptoms are noticeable but able to perform all activities.
◯ Symptoms are tolerated but may cause difficulty performing some activities.
◯ Symptoms interfere with performance of all activities.
◯ Symptoms are so severe that you are unable to perform any activity.

What is limited or makes your condition feel worse?

◯ Sitting	◯ Standing	◯ Walking	◯ Running	◯ Stairs
◯ Kneeling	◯ Bending at back	◯ Twisting at back	◯ Lifting	◯ Squatting
◯Repeated motion	◯ Bending at neck	◯ Rotating neck	◯ Desk work	◯ Driving
◯Mental stress	◯ Temperature	◯ Coughing	◯ Sneezing	◯ Other

Other:_____

_____

What activities with your *personal / work* lifestyle are <u>difficult</u> as a result of your symptoms / pain:

1	2
3	4
5	6

What makes your condition feel better?

◯ Rest	◯ Position changes	◯ Standing	◯ Hot compress	◯ Medication
◯ Lying Down	◯ Movement	◯ Exercise	◯ Cold Compress	◯ Stretching
◯ Massage	◯ Manipulation	◯ Knowledge	◯ Sleep	◯ Other

Other:_____

Sleep: ◯ Good ◯ Fair ◯ Poor / **Sleep Position**: ◯ Back ◯ Sides R / L ◯ Stomach ◯ Reclined
Average hours of quality sleep _____.
Activities performed 3 hours before sleep:_____

What treatment have you already received for this condition?

◯ Massage	◯ Surgery	◯ Counseling / Psyc	◯ X-Ray	◯ CT Scan
◯ Chiropractic	◯ Acupuncture	◯ Pain management	◯ MRI	◯ Bone Scan
◯ Injections	◯ Body Work	◯ Personal Training	◯ Sleep Study	◯ Doctor
◯ Other list:				
Medications for this condition:				

General Health (Please check / explain the categories that relate to your health below):

◯ Good	◯ Asthma	◯ Diabetes	◯ TMJ	◯ Cancer
◯ Autoimmune	◯ Gout	◯ Dizziness	◯ Vertigo	◯ Stroke
◯ Osteoarthritis	◯ Pregnant	◯ Post-Partum	◯ Headaches	◯ Short Breath SOB
◯ Rheumatoid Arth	◯ Hernia	◯ Implants	◯ Depression	◯ Vision
◯ Osteoporosis	◯ Digestive	◯ Pacemaker	◯ Bowell difficulty	◯ Bladder Difficulty
◯ Neurological	◯ Painful cycle	◯ Brain Trauma	◯ Concussions	◯ Hearing
◯ Sleep Apnea	◯ Sleep Disturbed	◯ Hormone	◯ Dental	◯ Other

Descriptions of above conditions and others:_____

_____

_____

Heart / Respiratory (Describe): _____

_____

Previous Injuries:_____

_____

All Previous Surgeries:_____

_____

_____

What assistive / adaptive equipment do you use:_____

_____

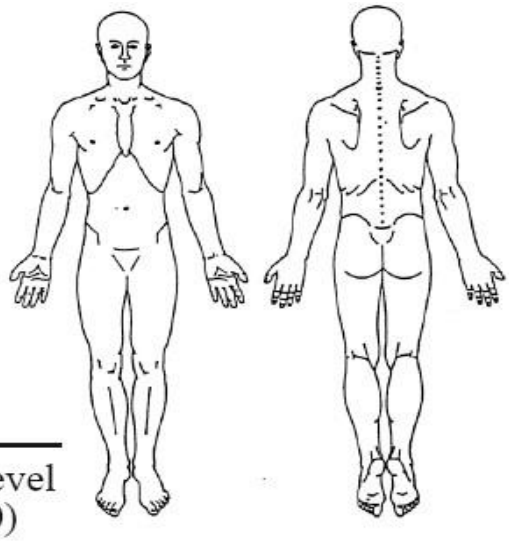
Other Thoughts:_____

_____

Pain/Symptoms

On the Body Diagram to the right, indicate your region of pain using the symbols below:

(X) Sharp
(+) Numb/Tingling
(#) Dull/Aching
(B) Burning



_____
Pain Level
(0-10)

Medications for other conditions

◯ List Provided	1	2	3	4
5	6	7	8	9

Approximately how many glasses of water do you drink per day:____ **Caffeine** Y / N **Smoke** Y / N

Do you have a regular exercise routine? Y / N Describe: _____
_____

Recreational Activities: _____
_____

Are you working? ◯ Yes / ◯ No > Reason: ◯ Retired ◯ Injury ◯ Disability ◯ Leave of Absence
Physical demands specific to your work: _____
_____

Goals with this Physical Therapy experience:

◯ Increase strength	◯ Knowledge	◯ Posture	◯ Symptom control	◯ Exercise
◯ Decrease pain	◯ Body Awareness	◯ Sleep Quality	◯ Balance	◯ Less stress
◯ Other List:				
What activities would you like to perform better:				

Signature:_____ Print Name:_____

"TO THOSE WHO SEEK THE DIFFERENCE, WE'RE AVAILABLE