HEALTH STAR PHYSICAL THERAPY, INC.

HEALTH INFORMATION AND CONSENT FOR TREATMENT

Patient Name: _____ Date: _____

Have you ever been treated for or diagnosed with any of the following? Please circle Yes or No.

Hearing Problem	Y	N	Balance Problems	Y	N	Nerve Damage/Disease	Y	N
Blood Pressure	Y	N	Taking Blood Thinner	Y	N	Pacemaker	Y	N
Heart Disease	Y	N	Neck/Back Problems	Y	N	Hernia/Rupture	Y	N
Heart Attack	Y	N	Circulation/Phlebitis	Y	N	Blood Disease	Y	N
Migraine Headache	Y	N	Joint Problems/Arthritis	Y	N	Any Spinal Surgery	Y	N
Visual Problems	Y	N	Breathing Problems	Y	N	Incontinence	Y	N
Diabetes	Y	N	Seizure Disorder	Y	N	Currently Pregnant	Y	N
Cancer	Y	N	Stroke	Y	N	Sinusitis	Y	N
Anxiety/Depression	Y	N	Neurological Condition	Y	N	Chronic Lung Disease	Y	N
Tobacco Use	Y	N	Alcohol Use	Y	N	Currently taking Pain Meds?	Y	N

Other _____

Are you allergic to any medication? Y N If yes, please explain _____

Past Surgeries _____

Have you *ever* been treated for the condition you are here for today? _____

If yes, when and where? _____

CONSENT FOR PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent to evaluation and/or treatment of my condition by the licensed physical therapist(s) employed by or under contract with HEALTH STAR PHYSICAL THERAPY, INC.

The physical therapist will fully explain to me the nature and purpose of the procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, attendant discomforts and risks that may arise, as well as alternatives to the proposed treatment and the risks and consequences of no treatment.

I understand that there is no guarantee that the proposed course of treatment will improve my condition and that it is possible that the course of treatment may cause additional pain or discomfort, and/or aggravate my existing condition. I will be given the opportunity to ask questions, and will have my questions answered to my satisfaction.

I confirm that I have read and fully understand this consent form.

_____ Date:_____

(Signature)

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to, the proposed evaluation and treatment. I have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

_____ Date: _____

(Physical Therapist Signature)