RADICAL RECOVERY & PERFORMANCE

Welcome! We are pleased that you have chosen Radical Recovery & Performance for your therapy needs. Our goal is to provide you with the highest quality care in a clean and professional environment. Please carefully read the following instructions to prepare you for your first visit.

What to expect the day of your appointment: Before we begin your therapy program, an evaluation will be performed to assess your individual needs. It is important that you come to your evaluation at least 15 minutes early to complete the necessary paperwork.

PLEASE BE PREPARED TO BRING THE FOLLOWING ITEMS TO YOUR APPOINTMENT

1. Therapy prescription from physician
2. Personal identification
3. Insurance card
4. List of medications you are currently taking
5. Comfortable clothing

Appointments: Regular attendance and active participation in your therapy program is necessary for you to get the maximum benefit from our services. It is also important for you to have open communication with your therapist about the therapy being provided and any pain you might be experiencing so that therapy can be adjusted to meet your needs. Our patients are seen by appointment only. It is critical that you are on time for your appointments. Being late may make it necessary to shorten your therapy session so it does not disrupt other patient's scheduled appointments.

Cancellations/Reschedules: Because we provide services by appointment, it is critical that you allow 24-hour notice if you must cancel an appointment. This is a courtesy to the clinical staff as well as to the other patients. Habitual cancellations may lead to discontinuation of services and/or notification to your physician and insurance carrier. If you are more than 15 minutes late and have not contacted Radical Recovery & Performance, we retain the right to consider your appointment a "No Show." As such, we reserve the right to charge Medicare patients a $40 fee and cash-patients the full amount for the session.

We truly do not want to have to charge you for session you did not attend. These policies are in place because we've found that they encourage patient cooperation and engagement in attaining their rehabilitation goals (rather than profiting from lack of compliance). Thank you for your understanding and participation.

By signing below, you acknowledge that you have read, understand, and agree to all the policies listed above.

Patient or Guardian Signature

Date

Printed Name

RADICAL RECOVERY & PERFORMANCE

PATIENT INTAKE

Full Name (as it appears on your insurance card) | Preferred Name/Nickname

Street Address | City | State | Zip | Phone Number

Date of Birth | Age | Gender | Email Address

INSURANCE INFORMATION

Primary Insurance | Primary Insurance ID Number

Secondary Insurance | Secondary Insurance ID Number

REFERRING PHYSICIAN

Name of Referring Physician | Referring Phone Number

Date of Next Visit to Referring Physician | Primary Care Physician | Primary Care Phone Number

HOW DID YOU HEAR ABOUT RADICAL RECOVERY & PERFORMANCE?

Please specify, so we may say "Thank You" _____

☐ Physician ☐ Former Patient ☐ Sports Team/Coach ☐ Dance School/Instructor ☐ Internet ☐ Other

Patient or Guardian Signature | Date

RADICAL RECOVERY & PERFORMANCE

INJURY INFORMATION/SYMPTOMS

Date of onset/injury: _____ Are symptoms new? ☐ YES ☐ NO

How did the injury occur? _____

Surgical procedure and date? _____

Describe your physical limitations as a result of your injury/surgery: _____

Describe any activities or movements that aggravate your symptoms: _____

Describe any treatments or movements that decreases your symptoms: _____

Please list any previous injury, conditions, or surgeries: _____

Have you had any of the following diagnostic tests related to your injury? (Mark all applicable)

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Doppler ☐ Ultrasound ☐ Other

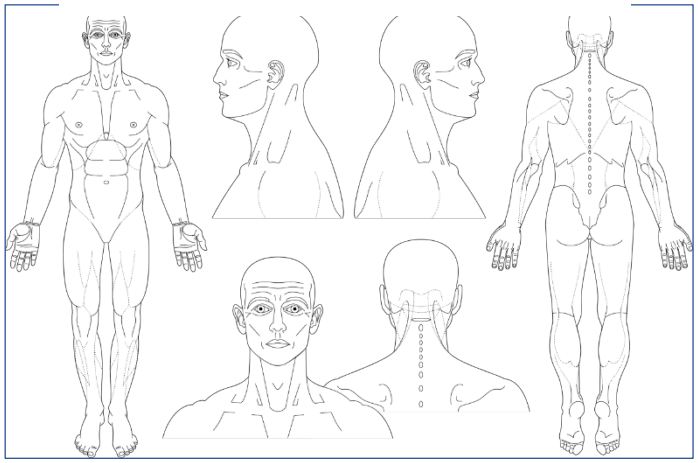
Which of the following describes your pain?
(Mark all applicable)

☐ Sharp ☐ Achy ☐ Burning ☐ Tingling ☐ Numbness ☐ Other:

Please rate your pain: (0=None, 5=Moderate, 10=Severe)

At Present	0	1	2	3	4	5	6	7	8	9	10
At Best	0	1	2	3	4	5	6	7	8	9	10
At Worst	0	1	2	3	4	5	6	7	8	9	10

Please mark all the areas of your symptom(s)



Are you currently taking ANY medications? ☐ YES ☐ NO

Please list ALL medication/dosage or provide written list: _____

Fall History: Is your injury the result of a fall? ☐ YES ☐ NO Have you fallen twice or more in the past year? ☐ YES ☐ NO

Date(s) of fall: _____

HEALTH HABITS AND LIFESTYLE

Is your diet well-balanced? ☐ YES ☐ NO Do you drink water regularly? ☐ YES ☐ NO Glasses/Day? _____

Do you smoke? ☐ YES ☐ NO Daily amount: _____ For how long? _____

Do you drink alcohol? ☐ YES ☐ NO Number/Day? _____ Days/Week? _____

Do you exercise regularly? ☐ YES ☐ NO How often? _____ Type/Program? _____

RADICAL RECOVERY & PERFORMANCE

MEDICAL HISTORY

Have you been diagnosed with any of the following conditions:

Allergies	Y	N	Depression	Y	N	Kidney Problems	Y	N
Anemia	Y	N	Diabetes	Y	N	Metal Implants	Y	N
Anxiety	Y	N	Dizziness/Ringing in ears/Vertigo	Y	N	Multiple Sclerosis	Y	N
Arthritis	Y	N	Emphysema/Chronic Bronchitis	Y	N	Neurological Disorder	Y	N
Asthma	Y	N	Fibromyalgia/Chronic Fatigue	Y	N	Numbness/Tingling	Y	N
Bladder/Bowel Problems	Y	N	Fractures	Y	N	Osteoporosis/Osteopenia	Y	N
Cancer	Y	N	Gastrointestinal Problems	Y	N	Pain Syndromes	Y	N
Cardiac Disease/Conditions	Y	N	Gallbladder Problems	Y	N	Parkinson's Disease	Y	N
Cardiac Pacemaker	Y	N	Headache/Migraines	Y	N	Seizures	Y	N
Defibrillator	Y	N	Hepatitis	Y	N	Speech Problems	Y	N
Circulation Problems	Y	N	Hernia	Y	N	Strokes	Y	N
Cognitive Disorder(s)	Y	N	High Blood Pressure	Y	N	Thyroid Problems	Y	N
Currently Pregnant	Y	N	Incontinence	Y	N	Vision Problems	Y	N

Have you suffered from any illness not listed above? ☐ YES ☐ NO If yes, please explain: _____

TREATMENT HISTORY

Have you been treated for this condition before? ☐ YES ☐ NO By whom? _____

Was it helpful? ☐ YES ☐ NO Please explain: _____

What are your goals for physical therapy? _____

What do you hope to get from your treatment? _____

What are your current physical or fitness goals? _____

PATIENT STATEMENT OF UNDERSTANDING

I understand, and acknowledge, the following statements:

- Therapy involves patient to provider person to person contact in a professional and medically necessary manner.
- Therapy involves some risks and hazards, most commonly including: Soreness, redness of skin, bruising, swelling, and pain.
- I may seek treatment from any therapy provider/facility that I choose.

I authorize and request Radical Recovery & Performance:

- Perform diagnostic assessments, examinations, procedures, and treatments to assess and treat my condition or injury.
- Release my medical records to any other provider or medical facilities directly involved in my care and for the purpose of administering claims and to obtain medication history for the purpose of treatment.
- Assign payment of my medical benefits to Healing Hands Therapy, LLC.
- Release information regarding my condition and my ability to return to normal activity and/or work to my insurance company/employer/attorney, or their representative.

_____ _____

Patient or Guardian Signature Date