



6701 W. Blondell St. Wasilla, AK 99654

Dear Valued Patient:

Thank you for choosing First Choice Physical Therapy for your therapy services. We strive to provide the best care for our patients. The staff will assist you with any area of need. Please do not hesitate to ask for assistance at anytime if you do not understand something.

There is a time on our schedule reserved especially for you and it is important that you be on time for your appointments. If you can't make an appointment, we request advanced notification of 24 hours. This will allow us to provide another patient with the opportunity to come in at that appointment time. Please be aware that after 3 "No Shows" we reserve the right to discharge you from our services. Please do not allow it to come to this. Our goal is to get you better and look forward to serving you. If "something comes up" please just give us a courtesy call and we will happily get you rescheduled to come in at a more convenient time.

Thank you for your time and cooperation in getting you back to better health! ☺

I have read and understand the above request.

---

Signature

---

Date



6701 W. Blondell St. Wasilla, AK 99654

Today's Date:

PCP:

**PATIENT INFORMATION**

Patient's last name: First: Middle:  Mr.  Miss  Mrs.  Ms. Marital status: Single  Mar  Div  Sep  Wid 
Is this your legal name?  Yes  No If not, what is your legal name? (Former name): Birth date: Age: Sex:  M  F
Physical address: Social Security no.: Home phone no.: ( )
P.O. box: City: State: ZIP Code:
Occupation: Employer: Employer phone no.: ( )
Chose clinic because/referred to clinic by (Please check one box):  Dr.  Insurance plan  Hospital
 Family  Friend  Close to home/work  Yellow Pages  Other
Other family members seen here:

**INSURANCE INFORMATION**

(Please give your ID and insurance card to the receptionist.)

Person responsible for bill: Birth date: Address (if different): Home phone no.: ( )
Is this person a patient here?  Yes  No
Occupation: Employer: Employer address: Employer phone no.: ( )
Is this patient covered by insurance?  Yes  No
Please indicate primary insurance:
Subscriber's name: Subscriber's S.S. no.: Birth date: Group no.: Policy no.: Co-payment: \$
Patient's relationship to subscriber:  Self  Spouse  Child  Other
Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:
Patient's relationship to subscriber:  Self  Spouse  Child  Other

**IN CASE OF EMERGENCY**

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: Work phone no.: ( ) ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to First Choice Physical Therapy. I understand that I am financially responsible for any balance. I also authorize First Choice Physical Therapy or insurance company to release any information required to process my claims.

Patient/Guardian signature

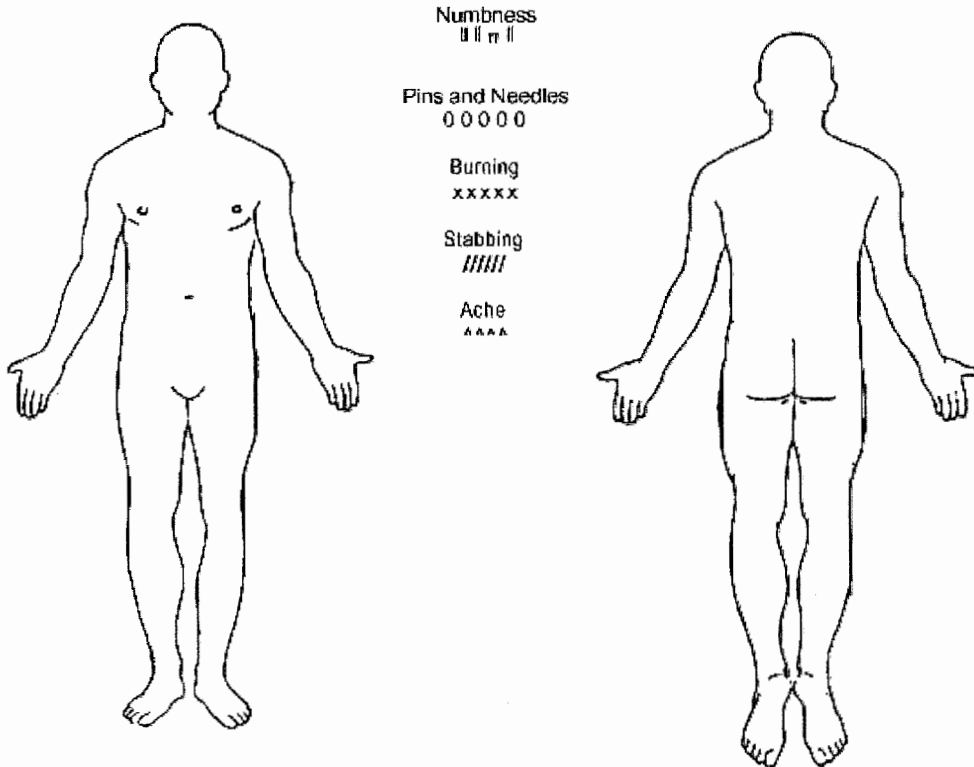
Date



6701 W. Blondell St. Wasilla, AK 99654

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mark these drawings according to where you hurt (if the back of your neck, circle the drawing on the back of the neck, etc.). If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram. Include all affected areas.



I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



6701 W. Blondell St. Wasilla, AK 99654

PATIENT MEDICAL HISTORY (Massage Therapy)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Have you had a massage before?  Yes  No

Are you here for an injury?  Yes  No

Is an attorney involved in this case?  Yes  No

Have you had surgery for this?  Yes  No

Type of surgery \_\_\_\_\_

Are you currently taking any prescription or non-prescription medications?  Yes  No

- Anti-Inflammatories  Yes  No
- Muscle Relaxers  Yes  No
- Pain Medication  Yes  No

List Medications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you had any of the following medical or rehabilitative services for this injury?

- |                      |  |                      |  |
|----------------------|--|----------------------|--|
| Chiropractor         | <input type="checkbox"/> Yes <input type="checkbox"/> No | CT Scan              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| EMG/NCS              | <input type="checkbox"/> Yes <input type="checkbox"/> No | General Practitioner | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Massage Therapy      | <input type="checkbox"/> Yes <input type="checkbox"/> No | MRI                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Accupuncture         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurologist          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Occupational Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthopedist          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Physical Therapy     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Podiatrist           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emergency Room Care  | <input type="checkbox"/> Yes <input type="checkbox"/> No | X-Rays               | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do you now have or have you ever had any of the following?

- |                                  |  |                               |  |
|----------------------------------|--|-------------------------------|--|
| Bruise easily                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Frequently suffer from stress    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Conditions               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Coronary Heart Disease or Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lymphadema/Lymph removal         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you wear contacts             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack or Surgery          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Implants                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke/TIA                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Replacement             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Clot/Emboli                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neck Injury/Surgery           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy/Seizures                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shoulder Injury/Surgery       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid/Goiter                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Elbow/Hand Injury/Surgery     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Back Injury/Surgery           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Infectious Diseases              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Knee Injury/Surgery           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leg/Ankle/Foot Injury/Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer or Chemotherapy/Radiation | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing Difficulties          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Swollen Joints         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Numbness                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Osteoporosis                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tingling                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |



6701 W. Blondell St. Wasilla, AK 99654

PATIENT MEDICAL HISTORY CONTINUED (Massage Therapy)

Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sleeping Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emotional/Psychological Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bowel or Bladder Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you smoke	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you are pregnant, how far along are you? \_\_\_\_\_

Other information that will assist us in your care: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What are your expectations/goals while in this program? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_

Date: \_\_\_\_\_



6701 W. Blondell St. Wasilla, AK 99654

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*You may refuse to sign this acknowledgement\*

First Choice Physical Therapy will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other healthcare operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution.

I, \_\_\_\_\_, have received a copy of First Choice Physical Therapy's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT  
Original completed consent to be filed in patient's medical record