New Patient Paperwork

Welcome to Evolution Physical Therapy! Thank you for choosing us to assist you in achieving your goals. We take pride in being the premier sports and orthopedic physical therapy company in Colorado and we are confident you will experience great outcomes while having fun doing it!

At Evolution Physical Therapy, our mission is to help all of our patients and clients perform at their highest potential. Our mission is to completely re-define the profession of physical therapy to provide the community with exceptional rehabilitation services, fitness and performance training, prevention and wellness. Our Doctor of Physical Therapist have the best skills, are equipped with the most state-of-the-art equipment, and have an unparalleled drive to help you get better.

This packet is meant to make your first visit to Evolution as seamless as possible. Please arrive 15 minutes early before your first session to complete any necessary paperwork. This can be expedited by completing the paperwork in this packet. Your session will last approximately 1 hour.

Remember to bring the following items with you:

- Government-issued photo ID
- Prescription or Doctor’s Orders for physical therapy (if issued)
- Insurance card(s)
- Form of Payment
- Comfortable clothing that allows your doctor to assess your injured body part and allows you to move!

PLEASE NOTE - We strictly enforce a 24 hour-notice cancellation policy

It is the responsibility of each patient to verify his/her physical therapy benefits with their insurance companies prior to initiating care. As a courtesy, we will do our best to confirm coverage with each patient's insurance plan, but that information is not a guarantee of benefits.

Evolution Physical Therapy NEW PATIENT FORM

PLEASE PRINT CLEARLY

Legal Name (First)_________________________(Last) ___________________________(M.I.) __________

Preferred Name: ____________________________ Gender ☐ Male ☐ Female

Home Address____

City____State_________Zip________________________

Cell Phone______________________Work Phone_____________________Other Phone____________________

Social Security #_____________________ Birth Date ________________ Age__________

Email Address____

Emergency Contact Name__________________________________ Relationship_____________________

Phone _____________________________________

Referring Physician_____________________________________ Phone _____________________________

Address____

Who may we thank for your referral other than your Doctor?_______________________________________

Employer______________________________________**Employment** Full / Part-time / Not Working / Retired

Address ____ Phone___________________________

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other__________________Injury Date ___________________

Attorney Involved Yes / No Attorney/Firm Name ____

Address ____ Phone #_______________________

Adjuster Name ____ Phone #_______________________

I attest that the above information is complete and true to the best of my ability.

Patient Signature:____**Date:** ___________________

(If patient is under 18 (signature must be parent or guardian)

Evolution Physical Therapy MEDICAL HISTORY

Patient Name ______________________________ Age ________

Type of Injury / Condition ______________________

Onset / Injury Date ______________________

Type of Surgery & Date ______________________

Next Doctor's Appointment? ______________________

Describe previous treatment for this condition______________________

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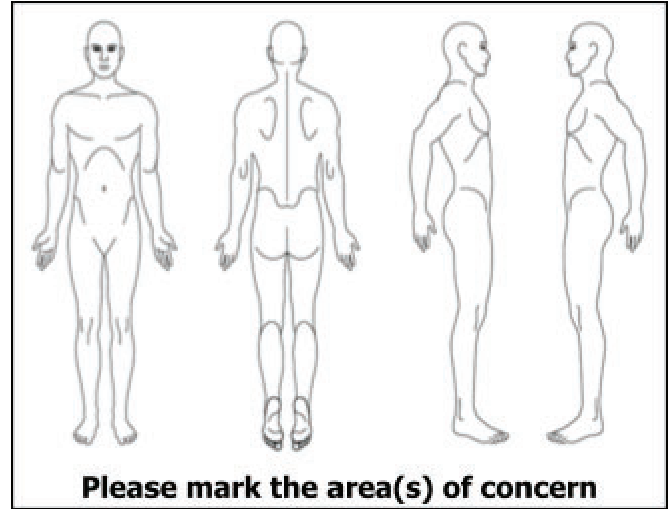
Please mark the area(s) of concern

Have you received chiropractic treatment this year? ☐ Yes ☐ No

Have you had any imaging performed:

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

Have you recently noted:

☐ Weight Loss /Gain
☐ Weakness
☐ Pregnant / IUD
☐ Pain At Night
☐ Nausea / Vomiting
☐ Fever / Chills / Sweats
☐ Headaches
☐ Cramps In Legs When Walking
☐ Fatigue
☐ Numbness / Tingling
☐ Change In Vision Or Hearing
☐ Insomnia

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

☐ Surgeries
☐ Sprains / Strains
☐ Heart Problems
☐ Circulation Problems / Clots
☐ Easy Bruising / Bleeding
☐ Indigestion / Heartburn
☐ Osteoporosis/Osteopenia
☐ Other: ______________________
☐ Loss of Consciousness
☐ Diabetes
☐ Cancer
☐ Asthma / Breathing Problems
☐ Leg / Ankle Swelling
☐ Fainting
☐ Depression
☐ Fractures
☐ Blood Pressure Problems
☐ Motor Vehicle Accident
☐ Lung Disease
☐ Urinary Problems / Infections
☐ Allergies / Skin Sensitivity
☐ Emotional/Psychological Disorder

Any previous injury that may affect current care? ______________________________

List Current Medications ______________________________

Type Of Pain: ☐ Sharp ☐ Burning ☐ Aching ☐ Tingling ☐ Numbness ☐ Other ______________

Rate your pain (1=minimal 10=extreme): At its worst: 1 2 3 4 5 6 7 8 9 10 / At its best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? ______________________________

What are your physical or fitness goals? ______________________________

Is there anything else you would like to include or ask your physical therapist? ______________________

X______________________________________ ______________

Patient or Personal Representative Signature **Date**

Office Policy

Consent to Treat

I consent to have Evolution Physical Therapy and/or its affiliates provide the treatment and care considered necessary and proper in diagnosing and treating my condition. I understand this consent may be revoked by me at any time. I agree that I assume all risks and responsibilities involved in participating in physical therapy through Evolution, and waive, release, and forever discharge Evolution Physical Therapy and their owners, directors, employees, or any person acting on their behalf, from all claims, demands, liability, and damages relating to, arising out of, or resulting from my participation in physical therapy provided by Evolution Physical Therapy. Patients below the age of 18 must have a legal guardian provide consent on their behalf.

Social Media Disclosure

I understand that while in Evolution Physical Therapy facilities I may be a background to a subject in social media platforms. If I am to be the subject, verbal consent will be obtained to produce content.

Workers' Compensation Claims

If you claim Workers' Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

Release of Information and Assignment of Insurance Benefits

I authorize Evolution Physical Therapy or its legal representatives to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or evaluation rendered to me during the period of such care. I hereby authorize payment of medical benefits to which I am entitled to Evolution Physical Therapy for medical services rendered.

Supply Charges/Retail

We may provide treatments for which supplies are not covered by insurance. We will not bill insurance for these supplies, and the patient is responsible for related supply charges.

HIPAA Private Practices

I have read and consent to the assumption of risk and release and the HIPPA practices adopted by Evolution Physical Therapy. I understand that non-identifying patient data may be used in research and/or publication and consent to such use. I understand that I may obtain a paper copy of the Evolution Physical Therapy Privacy Practices at any time by asking the Front Desk.

____ ______________________________

Patient /Guardian/Responsible Party Signature **Date**