

Mission Peak Physical Therapy Pilates Intake Forms

Profile Information — Step 1 of 3

Please take a moment to fill out our online intake form before your visit.

First Name: _____

Last Name: _____

Preferred Name: _____

Prefix / Title: _____

Email: _____

Mobile Phone: _____

Home Phone: _____

Work Phone: _____

Street Address: _____

City: _____ State: _____

Date of Birth: _____

Gender: _____

Primary Care Physician: _____

Primary Care Physician Phone (if known): _____

Name of Referring Professional (if applicable): _____

Referring professional phone (if known): _____

Occupation: _____ Employer: _____

How did you hear about us? (ie. Doctor, friend, online directory drove-by, returning patient):

Questionnaires — Step 2 of 3

Pilates Intake Form: This form contains a series of questions designed to help your physical therapist/Pilates instructor understand your current fitness status and the goals you desire to accomplish with Pilates services. This information will help your provider give you the best possible care. Please answer every question as accurately and completely as you can. If your medical information changes during the course of your physical therapy care, it is your responsibility to notify your provider of these changes.

Please list 3 goals you would like to achieve with Pilates:

1. _____
2. _____
3. _____

Please list injury history including any current areas of pain or concern: _____

Medical/Health History (Please check all that apply):

- Hypertension Low Blood Pressure Heart Disease Stroke/CVA Pacemaker
- Asthma COPD Other Pulmonary Conditions Diabetes Seizure/Epilepsy
- Dizziness/Vertigo Arthritis Cancer Currently Pregnant

Please List any Current Medications: _____

Please List any Allergies: _____

Surgical History (please list type of surgery and date or surgery):

Do you currently Exercise? (Please include type of exercise and frequency): _____

Have you participated in Pilates before? (If Yes, please check box of type of Pilates):

Reformer Mat

Consents — Step 3 of 3

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

- I would like email notifications of new, cancelled, and rescheduled appointments
- Email 2 days before appointment Text Message (SMS) 24 hours before appointment

News and Special Promotions

- Yes, I would like to receive news and special promotions from Mission Peak Physical Therapy by email

Pilates Intake Form — Consents

Accuracy of Information

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information or omitting information can be dangerous to my health. It is my responsibility to inform my physical therapist of any changes in my medical condition.

- * I certify that the above medical information is correct to my knowledge.

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my primary care physician and/or referring provider, including the staff members of those providers, as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be

disclosed to third parties other than my primary care provider and/or referring provider and their staff members with my permission.

* I have been received notice, read, and understand my privacy rights and practices.

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapist's day that could have been filled by another patient. As such, we require 24 hours' notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours' notice, or miss their appointment, will be charged a \$50 cancellation fee. Patients who need to cancel due to personal and family emergency or sudden illness will not be charged a fee; if an emergency or sudden illness occurs, please notify the clinic as soon as possible.

* I am aware of the Cancellation Policy.

Consent to Treatment

I grant permission for licensed physical therapists at Mission Peak Physical Therapy PLLC to perform such examinations and therapeutic treatments and/or procedures as may be professionally deemed necessary for appropriate evaluation and treatment of my condition.

For Minors: I (patient or legal guardian for patient who is a minor) grant permission for licensed physical therapists at Mission Peak Physical Therapy PLLC to perform such examinations and therapeutic treatments and/or procedures as may be professionally deemed necessary for appropriate evaluation and treatment of the condition of my child.

* I consent to treatment as described above.

Financial Agreement

Mission Peak Physical Therapy PLLC will require full payment for Pilates sessions at the time of service. I understand and agree that the entire cost of these services is my financial responsibility.

* I agree.

Signature: _____

Printed Name: _____

Date: _____

Parent/Guardian Signature: _____

Printed Name of Parent/Guardian: _____

Date: _____