

# LeBauer Physical Therapy

## New Patient Information Sheet

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Last name First name

Address: \_\_\_\_\_  
Street Apt # City State Zip

Phone Number: Mobile (\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Marital Status: M S W D

Emergency Contact: Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Date of next visit: \_\_\_\_\_

Specialist Physician: \_\_\_\_\_ Date of next visit: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Did anyone refer you? \_\_\_\_\_ Name: \_\_\_\_\_

*The following is very important in our evaluation process.*

*Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.*

What is the primary complaint that brings you in today?

**Please shade in areas where you have pain, discomfort, or tension.**

Secondary complaint?

As a result, I am now having difficulty with:

Are you currently experiencing pain as a result of these symptoms? \_\_\_\_\_

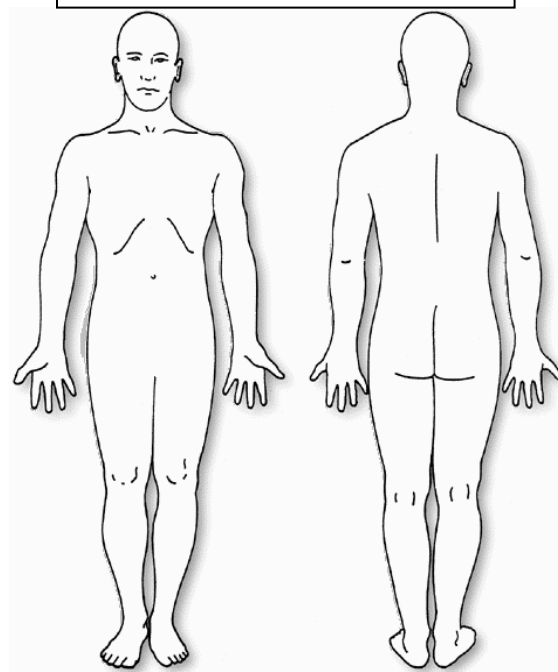
When did your symptom(s) begin?

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

Please rate the intensity and Frequency of your pain with "0" being no pain, "5" being moderate pain, and "10" being unbearable pain.

Your **Pain Intensity** Rating: \_\_\_\_\_

Your **Pain Frequency** Rating: \_\_\_\_\_



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More specifically, rate your pain using the same "0" to "10" scale.

At its worst \_\_\_\_\_  
At its best \_\_\_\_\_  
At present \_\_\_\_\_  
Night (sleeping) \_\_\_\_\_

At what time of day are your symptoms the worst? \_\_\_\_\_

At what time of day are your symptoms the best? \_\_\_\_\_

What activities increase your pain? \_\_\_\_\_

What activities decrease your pain? \_\_\_\_\_

What other types of treatment have you had for this problem?

Massage     Bodywork     Physical Therapy     Myofascial Release     Chiropractic  
 Surgery     Other Medical Treatment: (Please Describe) \_\_\_\_\_

Check the box if you have had any of the following medical conditions?

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Neurological problems
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Circulatory problems	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Broken bones (fracture)
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Heart disease/pacemaker	<input type="checkbox"/> Malignancy	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Metal implants
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Blackouts
<input type="checkbox"/> Weight change	<input type="checkbox"/> Other: explain _____	

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

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List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).

Medication	for treatment of	Dose/Amt. per day	Effectiveness
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



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List the activities that you would like to be able to do as a result of therapy.

Activity	Duration/How Often	By When
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Other Goals? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*I understand that LeBauer Physical Therapy, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.*

*By signing below I acknowledge that I have been offered a HIPAA information sheet, that I can request one at any time in the future, and that I may ask for clarification of HIPAA regulations at any time.*

*Photographs taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below I consent to the use of these photographs in a professional manner.*

*I do hereby agree and give my consent for LeBauer Physical Therapy, LLC to furnish care and treatment which is considered necessary and proper in the diagnosing or treating of my physical condition.*

*I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.*

*I hereby certify that all the above information is true to the best of my knowledge.*

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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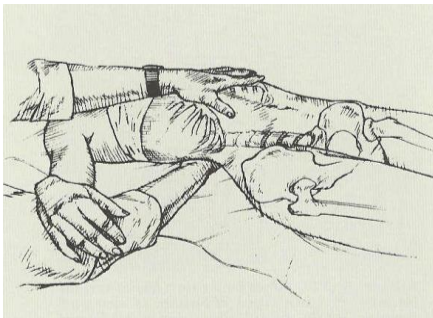
### Informed Consent for Manual Therapy Techniques

The following information is being provided to you, in order that you better understand what types of techniques your therapist *may* use during your treatment.

Myofascial release, Craniosacral therapy and massage are all interventions that require “hands-on” contact. Therefore the therapist will ask you to dress appropriately to allow for proper treatment. For example women may choose to wear a bathing suit top or tank top and shorts, men may choose to wear shorts. Throughout the session, you may at *any time* ask your therapist to “ease up”, or “stop” treatment completely. If hand placements make you feel uncomfortable, please say so immediately. In addition if you would like to have an aide, companion or family member in the room, please request this.

Below are pictures of *manual therapy techniques* being used to release areas of tissue restrictions. Your therapist will provide you with further educational information to better understand the anatomy of the myofascial and craniosacral system.

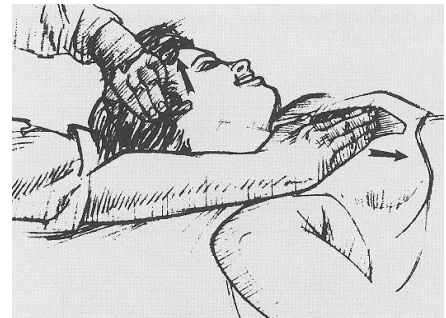
#### Examples of hand placements:



Respiratory diaphragm release



Thoracic inlet release



Lateral neck release



Arm-pull



Psoas area release



Anterior hip release

By signing below I acknowledge that I have read and understand the above, and I consent to receiving these and other manual therapy techniques from my therapist.

Patient name: \_\_\_\_\_

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

Patient signature: \_\_\_\_\_

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### Cancellation and No Show Policy

All cancellations need to be made 24 hours prior to your appointment. If you do not show up for your appointment or cancel with-in 24 hours, you will be responsible to pay for 100% of the session.

### Payment Policy

Therapy sessions are \$95 for a standard 50-minute session. Your initial evaluation is \$125. Custom orthotics are \$250. Payment, in the form of cash, check or credit card, is due at the time of each visit.

We are not contracted with any insurance companies. However, the payments you make may be reimbursable by your insurance company under your out of network physical therapy benefits; the exact percentage depends upon your plan. Due to the complex nature of insurance claims and reimbursement, I make no promises as to whether you will receive reimbursement.

We will assist you in every way possible. Payment is due at the time on service.

I have read and understand the above policies:

Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Thank you for your cooperation and business.

Aaron LeBauer PT, DPT, LMBT  
LeBauer Physical Therapy, LLC