Chris Fahs Physical Therapy, LLC

400 S McCaslin Blvd, Suite 210, Louisville, CO 80027
630-605-4336
chrisfahspt@gmail.com
chrisfahspt.com

Full Name: ____
First M.I. Last

Birth Date: ____/____/_____ Age: _____ Sex: M F

Address:____
Street
____
City State Zip

Phone: Cell __________________________ Home: _____________

Email: ____

How did you hear about me? (please circle)

Family Friend Another Medical Professional The Jones Institute

Please provide the name of the person who referred you: ____________

EMERGENCY CONTACT

Full Name:
____
First M.I. Last

Phone: Cell __________________ Home: ___________________

CURRENT HEALTH INFORMATION

Primary Complaint: ______________________________________

Pain Location: ____

Pain Quality: Constant Intermittent Dull/Achy Sharp/Stabbing Burning
Numb Tingling Cramping Sore

Other: ____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
No pain Annoying Worrisome Bothersome Can't move ER

My symptoms are: Mild Moderate Severe

My symptoms are getting: Better Worse Staying the Same

Prior Treatment: ____

Secondary Complaint: ______________________________________

Pain Location: ____

Pain Quality: Constant Intermittent Dull/Achy Sharp/Stabbing Burning

Numb Tingling Cramping Sore

Other: ____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
No pain Annoying Worrisome Bothersome Can't move ER

My symptoms are: Mild Moderate Severe

My symptoms are getting: Better Worse Staying the Same

Prior Treatment: ____

Additional Complaints:____

____

____

____

Daily Activities

Describe how your condition is limiting your function with:

Work: ____

Home: ____

Recreation: ____

Do you exercise regularly: Y N Frequency: ________________________

What do you do for exercise? _______________________________________

MEDICAL HISTORY

Please check all that apply to you:

- ❏ Headache
- ❏ Sinus Issues
- ❏ Rashes/skin Issues
- ❏ Rheumatoid Arthritis
- ❏ Osteoarthritis
- ❏ Osteoporosis
- ❏ Degenerative Disorders
- ❏ Digestive Issues
- ❏ Concussion/Dizziness
- ❏ Depression
- ❏ Chronic Pain
- ❏ Heart Disease
- ❏ Blood Pressure Issues
- ❏ Respiratory Disease
- ❏ Cancer
- ❏ Diabetes
- ❏ Other: ____

Please explain any checked boxes above:

____

____

____

Please list all medications you are currently taking: _____________________

____

____

Informed Consent and Patient Agreement

With the knowledge I acquired during my initial evaluation with Chris Fahs Physical Therapy LLC, realizing that Chris Fahs Physical Therapy LLC has given me no guarantees regarding cure or improvement of my condition, I hereby release Chris Fahs Physical Therapy LLC, from any and all liability which may occur in connection with treatment except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in treatment at any time. I understand that treatment requires clinician to gently touch and manipulate aspects of my body. I understand that treatment is not a substitute for medical care and that it is recommended that I work with my Primary Care Physician. I ensure that I have, to the best of my ability, made Chris Fahs Physical Therapy LLC aware of all my current medical conditions and medications. I understand that in extreme cases, treatment may result in symptoms worsening and soreness. I release my Physical Therapy of any liability if I fail to disclose the appropriate health related information.

I understand that a record of health services provided will be kept. This record will be kept confidential and will not be released to others unless directed by my representative or myself, or unless required by law. I understand that my Physical Therapist will answer any questions that I have and that I may request a copy of the current Notice of Privacy of Practices at any time.

I authorize Chris Fahs Physical Therapy LLC to provide treatment:

Patient Signature: __________________________ Date: ______________

(If applicable) Name of Child or Dependent: _________________________

Parent or Guardian Signature: ________________________Date: _______

Policies and Procedures

Treatment Rates:

The current rate for treatment is $150.00/55 minutes

Cancellation Policy:

All services are provided by appointment only and this time is reserved for your exclusive time use. It is your responsibility to attend all scheduled appointments. Should you need to cancel an appointment, please do so 24 hours before your scheduled appointment. Failure to do so will result in a Cancellation Fee of half the full rate of the appointment. Not showing for an appointment without giving notice to Chris Fahs Physical Therapy LLC will result in a No Show Fee of the full rate of the scheduled appointment. Occurrence of multiple no shows may result in discharge from the practice.

The patient is ultimately responsible for all charges of labor rendered to you by Chris Fahs Physical Therapy LLC. Payment in exchange for time and labor is due upon conclusion of each treatment. Trades must be discussed prior to the rendering treatment.

By signing below, I confirm that these policies have been explained to me in terms which I understand.

Patient Signature: _________________________Date: _______________

Parent or Guardian Signature: _____________________ Date: _________