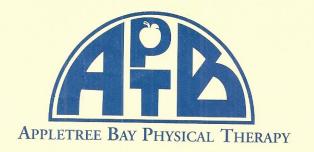
Name:		Email:			
Please circle the following	condition that you no	w, or have ever had,	a problem with.		
Allergies	Dizzy Spells		MRSA		
Anemia	Emphysema/	/Bronchitis	Multiple Sclerosis		
Anxiety	Fractures		Muscular Disease		
Arthritis	Gallbladder F	Problem	Osteoporosis		
Asthma	Headaches		Parkinson's		
Autoimmune Disorder	Hearing Impa	airment	Rheumatoid Arthritis		
Cancer	Hepatitis	,	Seizures		
Cardiac Conditions	High Choleste	erol	Smoking		
Cardiac Pacemaker	High Blood Pi		Speech Problems		
Chemical Dependency	Low Blood Pr		Strokes		
Circulation Problems	HIV/AIDs		Thyroid Disease		
Currently Pregnant	Incontinence		Tuberculosis		
Depression	Kidney Proble		Vision Problems		
Diabetes	Metal Implan		Fibromyalgia		
Describe any other condition Fall History: Injury as a result Have you had two or more in Surgical History: Body Region	lt of a fall in the past y	Yes No			
Medications	Dosage	Route (oral,injectio	n,patch) Reason for taking		
Height:			£		
Occupation/Job Duties:					

Other Activities and hobbies?_____



Acknowledgement of Notification

I, acknowledge that I have been presented with a copy of the Notice of Privacy Practice read and review, and have been given the opportunity to receive a copy of the notice.		
Signature	Date	
Signature of Representative (if applicable)	Date	

CONSENT FOR TREATMENT: I, the undersigned, knowing that I am suffering from a condition requiring health care, do hereby, voluntarily consent to evaluation of and treatment for my condition by the therapists of Appletree Bay Physical Therapy, Inc. I understand that the information collected during my evaluation and treatment may be helpful to others with my condition and I, hereby, consent to have that information gathered, studied and reported for research purposes in a manner that will not divulge my identity.

RELEASE AND ASSIGNMENT OF BENEFITS: I authorize the release of my medical records to process the claim or assist in my medical care. I also authorize Appletree Bay Physical Therapy, Inc. to submit insurance carrier claim forms on my behalf without further signature authorization. This also authorizes Appletree Bay Physical Therapy, Inc. to receive payment directly from the insurance carrier. All claim forms will be submitted to the carrier with the notation "Signature on File".

I understand and agree to the above consent for treatment, release and assignment of benefits.

Signatu	re (Guardian signature if minor)	Date
feels t	day we bring our dog, Rosie, to work with us. Ily and loves to be around people. We know the same way about Rosie that we do, and we ree make a checkmark on the lines if either of the	at not everyone
	I am allergic to dogs/pet dander.	
	I would feel better if Rosie were kept out of the while I have my therapy.	treatment area
	I don't mind if Rosie is in the treatment area d	uring my

Thank you for your honesty!

Andy Rubman, PT and Megan Rubman, PT