Name: _____ Email: _____

Please circle the following condition that you now, or have ever had, a problem with.

Allergies	Dizzy Spells	MRSA
Anemia	Emphysema/Bronchitis	Multiple Sclerosis
Anxiety	Fractures	Muscular Disease
Arthritis	Gallbladder Problem	Osteoporosis
Asthma	Headaches	Parkinson's
Autoimmune Disorder	Hearing Impairment	Rheumatoid Arthritis
Cancer	Hepatitis	Seizures
Cardiac Conditions	High Cholesterol	Smoking
Cardiac Pacemaker	High Blood Pressure	Speech Problems
Chemical Dependency	Low Blood Pressure	Strokes
Circulation Problems	HIV/AIDs	Thyroid Disease
Currently Pregnant	Incontinence	Tuberculosis
Depression	Kidney Problems	Vision Problems
Diabetes	Metal Implants	Fibromyalgia

Describe any other conditions or precautions: _____

Fall History: Injury as a result of a fall in the past year? Yes No

Have you had two or more falls in the last year? Yes No

Surgical History:

Body Region	Surgery Type	Date

Medications	Dosage	Route (oral,injection,patch)	Reason for taking

Height: _____ **Weight:** _____

Allergies: _____

Occupation/Job Duties: _____

Other Activities and hobbies? _____

APPLETREE BAY PHYSICAL THERAPY

Acknowledgement of Notification

I, _____ acknowledge that I have been presented with a copy of the Notice of Privacy Practices to read and review, and have been given the opportunity to receive a copy of the notice.

_____ _____

Signature **Date**

_____ _____

Signature of Representative (if applicable) **Date**

• 1205 North Avenue • Burlington, VT 05408 • Phone: 802-383-0400 • Fax: 802-383-0420 •

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.

_____ _____

Signature (Guardian signature if minor) Date

Each day we bring our dog, Rosie, to work with us. She is very friendly and loves to be around people. We know that not everyone feels the same way about Rosie that we do, and we respect that. Please make a checkmark on the lines if either of these apply to you!

____ **I am allergic to dogs/pet dander.**

____ **I would feel better if Rosie were kept out of the treatment area while I have my therapy.**

____ **I don't mind if Rosie is in the treatment area during my therapy.**

Thank you for your honesty!

Andy Rubman, PT and Megan Rubman, PT