STRIDE
PHYSICAL THERAPY
Take the Next Step

Please complete this confidential form prior to your appointment, scan and email it to Stridehometherapy@gmail.com

1. CLIENT INFORMATION

Name: _____

Date of Birth: _____ Age: _____

Address: (City/State/Zip)_____

Phone: _____ Email:_____
Emergency Contact: _____Phone:_____
Who may we thank for referring you? _____

2. RECENT SYMPTOMS

Briefly Describe what you would like to address at our upcoming Visit:

_____

_____

_____

_____

_____

_____

If there is Pain:

Pain Scale (0-10): Current: ____ Best (24hrs): _____ Worst (24hrs):_____
What makes symptoms worse? _____
What makes symptoms better? _____
Previous Imaging?: (X-Ray, MRI, etc.) _____

Please check those CURRENT Issues which apply with dates/time frames:

- ☐ Cough / Runny Nose _____
- ☐ Chest Tightness / Difficulty Breathing_____
- ☐ Loss of Taste or Smell _____
- ☐ Numbness/Tingling (Arms/Hands or Legs/Feet) _____
- ☐ Weakness (Hands/Grip or Muscle Fatigue) _____
- ☐ Fever / Chills / Sweats _____
- ☐ Dizziness / Fainting / Lightheadedness _____
- ☐ Changes in Bowel/Bladder Function _____
- ☐ Falls in the past 6 months (how many?) _____
- ☐ Vision Changes / Ringing in Ears _____
- ☐ Headaches (Location/Duration):_____

3. BRIEF MEDICAL HISTORY

Please indicate if you have a history of any of the following:

- ☐ Cancer
- ☐ Heart Disease
- ☐ Skin sensitivity
- ☐ Epilepsy or seizures
- ☐ Light sensitivity
- ☐ Stroke
- ☐ High or low blood pressure
- ☐ Heart disease,
- ☐ Circulation problems: Blood clots, Vascular disease, Anemia
- ☐ Lung problem: Pneumonia, Asthma
- ☐ Diabetes
- ☐ Osteoporosis/osteopenia
- ☐ Osteoarthritis
- ☐ Autoimmune Disease Rheumatoid arthritis
- ☐ Thyroid problems
- ☐ Obesity/anorexia
- ☐ Concussion/Head injury Headaches, Migraines Sinus problems
- ☐ Eye or vision problem
- ☐ Chemical dependency, alcoholism
- ☐ Depression, Anxiety,

Allergies: _____

_____

4. LIFESTYLE & ACTIVITY

Occupation: _____

Hours of Sleep: _____

Sports/Hobbies: (e.g., Golf, Running, Cycling, Lifting, etc.) _____

_____

_____

Tobacco Use: Yes No (Packs per day:_____).
Alcohol Consumption:_____drinks per week.

5. CLINIC POLICIES & CONSENT

1. I understand Stride Physical Therapy, PLLC is a private payer service and does not submit claims to insurance providers for reimbursement.

2. The Cancellation Policy: 48-hour notice is required.
    a. - Late Cancellation (if within 48hrs of appointment): $75 fee.

    b. - No Show (not at home or at agreed upon location): Full $150 fee regardless of package agreed upon.

3. Privacy (HIPAA): Stride is fully HIPAA compliant and will require me to sign a release of medical records form, or give verbal consent, in order to discuss my medical situation or records with any third parties.

4. Assumption of Risk: I acknowledge that I am aware of and understand the risks and dangers associated with Home Therapy including but not limited to: strengthening, soft tissue massage, balance training and fall prevention. I understand and am informed that in the practice of therapy, there are some risks;

including, but not limited to: fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, bruising, sprains, and muscle soreness. I do not expect physical therapists to be able to anticipate and explain all risks and complications. I wish to rely on the healthcare providers to exercise judgment during the treatment based upon the facts then known, in my best interests. I voluntarily assume full responsibility for any and all risks of loss, property damage, or personal injury that may be sustained by me as a result of my participation.

5. Release and Waiver: In consideration for being allowed to participate in Home Therapy, I hereby release, waive, and forever discharge Stride Physical Therapy, PLLC, along with their officers, employees, and agents, from any and all liability, claims, or demands for personal injury, sickness, or property damage of any kind arising out of my participation in Home Therapy.

6. Indemnification: I agree to indemnify and hold harmless Stride Physical Therapy, PLLC from any and all claims or expenses, including attorneys' fees, arising from any claim or lawsuit brought by me or any third party associated with my actions during Home Therapy.

7. Governing Law: This Agreement shall be governed by and construed in accordance with the laws of the State of Idaho.

8. ACKNOWLEDGEMENT:
   I certify that I am at least 18 years of age and legally competent to sign this agreement. I have read this document and fully understand that by signing, I am giving up my legal rights and remedies to sue Stride Physical Therapy, PLLC for any reason related to Home Therapy.

Client's Printed Name:_____

Client's Signature:_____ Date:_____

Witness's Printed Name: _____

Witness's Signature:_____ Date:_____

(I will sign this on the first visit.)

Please Email to: Stridehometherapy@gmail.com, Thank you!!