

QUANTUM
Physical Therapy & Wellness
3259 Prospect St, NW Washington, DC 20007 (202)-288-5389

Patient Registration

Name: _____ Date: _____

DOB: _____ Email: _____

Address: _____

Phone: _____ Work: _____ Cell: _____

Employer: _____ Occupation _____

Emergency Contact: _____ Relationship to pt: _____

Referring Medical Practitioner: _____

How did you hear about QPTW? _____

Patient picture identification is required prior to receiving services from QPTW _____

Quantum Physical Therapy & Wellness does not participate with any insurance companies. Patients are required to pay at the time of service and will be given a “Superbill” and receipt to submit to their insurance provider for reimbursement. QPTW cannot be responsible should your insurance company decide not to reimburse you. Please understand your out-of-network medical coverage and prescription requirements.

Patient Signature _____ Date _____

Medical History Disclosure Form

Name: _____ Age & DOB: _____

What areas of the body (ie-neck, L hip, R knee, etc) or conditions (ie, fibromyalgia, osteoarthritis, etc) are you currently seeking physical therapy treatment for? If there are multiple areas, which one is of greatest concern?

Have you ever been treated for this same problem before? When, what, where, by who?
Did prior treatment successfully manage or resolve the problem at that time?

Please circle any/all illnesses you've either had in the past or currently have:

Cardiovascular disease	Asthma/Breathing difficulty	Hepatitis/Liver disease
Depression	High Blood Pressure Congestive	Heart Failure Epilepsy/Seizures
Anemia	Diabetes (I or II)	Multiple Sclerosis
Thyroid condition	Osteoporosis	Stroke or Heart Attack
Fibromyalgia	Neurological condition	Chronic infections
Arthritis (Osteo/Rheum)	Migraines/Headaches	Eating disorder
Lupus	Kidney/Renal disease	Dizzy/Vertigo
Drug or Alcohol abuse	HIV/AIDS	

Cancer (Type) _____; Location(s) _____; Year _____
Status _____
Other: _____

Do you have any implanted medical device?

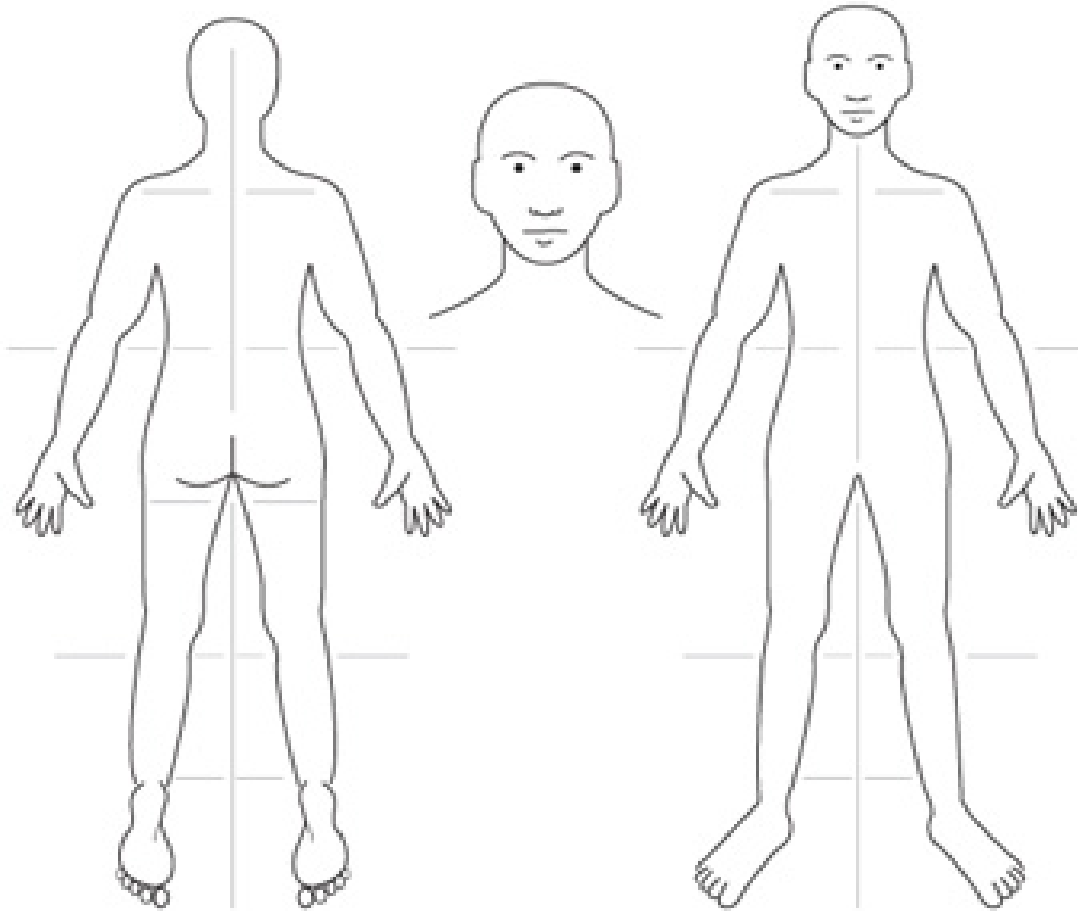
Please list all prescription medications you are presently taking & reason for medication (ie, Prozac for Depression, Percocet for pain, Accupril for High Blood Pressure):

Are you currently pregnant or is there even a possibility you may be pregnant?

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE & TRUE. IF MY MEDICAL/HEALTH STATUS CHANGES I WILL INFORM YOU IMMEDIATELY.

Signature & Date: _____

Please mark the drawings with the following letters to indicate areas of pain (P), numbness (N), tingling (T), or weakness (W):



Please rate your pain using this scale. Also, please indicate which area(s) of your body the score(s) applies to: (0=No pain, 10=Emergency Room pain)

0-----10

Cancellation Policy:

Quantum Physical Therapy & Wellness believes that each appointment you have scheduled is very important either for your treatment process or that of another who could potentially fill the time slot. Due to this belief QPTW has instated the following cancellation policy.

1. Please allow for 24 hour notice with all cancellations.
2. QPTW charges \$50 for all cancellations made within 24 hours prior to your scheduled appointment time. This applies to all cancellations regardless of cause.
3. If you cancel or no show for more than three appointments, all remaining appointments will be canceled until all fees are paid and you have talked directly with the therapist regarding your commitment to physical therapy at this time.
5. At the discretion of the physical therapist, you may be discharged from PT services or required to schedule your appointments one at a time if more than five cancellations occur during the course of treatment.

Please note that an appointment is only CHARGED as a cancellation if you do not give 24 hour notice.

I have read and understand this cancellation policy for QPTW. If I had any questions regarding this policy they were answered by the staff.

Signature of patient/ guardian: _____ Date: _____

Consent to Treat

I, _____, give Quantum Physical Therapy & Wellness and its therapists permission to evaluate me for a physical therapy condition and provide treatment which will include manual therapy, therapeutic exercise, movement re-education, patient education regarding my problem, and/or other modalities deemed necessary by the therapist. I understand that what treatment I am provided is with the professional discretion of my physical therapist. I agree to verbally share with my therapist if I need further explanation of the treatment or if I am unable to fully participate with assignments given by my physical therapist. I understand that in order for me to fully benefit from the treatment provided at QPTW, I WILL HAVE TO PARTICIPATE ON MY OWN BEHALF OUTSIDE OF MY TREATMENT SESSIONS. This might include performing home exercises at the frequency assigned by my therapist, posture modification, self myofascial treatment, or anything else my therapist suggests for me to do to progress my healing process.

In order for my therapist to most effectively treat me with manual therapy, I may be asked to remove some clothing or wear little clothing during treatment. I understand that if I am uncomfortable with this, I will share my concerns with my therapist and she will abide by my request.

Patient Signature _____ Date _____