

BODYBENDERS

**PHYSICAL THERAPY
WITH A TWIST**

Client Name: _____ Date of Birth: _____

Parent/Guardian Name: (Father) _____ (Mother) _____

Parent's Marital Status: (Married, Single, Divorced, Widowed) _____

Home Address: _____

E-mail Address: _____

Please check if you consent to e-mail correspondence

Phone: (Home) _____ (Father's Cell) _____ (Mother's Cell) _____

Father's Occupation: _____ Employer: _____

Work Address: _____ Phone: _____

Mother's Occupation: _____ Employer: _____

Work Address: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Please list anyone involved in the payment or routine care of this client with whom BodyBenders may share medical information (caregivers, educators, friends, extended family):

Please indicate if you DO NOT consent to the following:

I DO NOT provide consent for messages to be left on voice mail at the following phone number(s):

I DO NOT provide consent for messages to be left with any person in the household besides the parent/guardian.

Referring Physician: _____ Phone: _____

Date of last visit: _____ Date of next visit: _____

Primary Care Physician: _____ Phone: _____

Specialists: _____ Phone: _____

_____ Phone: _____

School/Grade: _____

School/Early Intervention Therapists: _____ Time per week: _____

OVER

Diagnosis/Condition:

Date of Onset:

Gestational History:

Birth History:

Prior Hospitalizations/Surgeries:

Medications:

Allergies:

Equipment:

Vendor:

Siblings/Ages:

Developmental Milestones (Please indicate the approximate age when achieved):

Rolling

Sitting

Crawling

Standing

Walking

Other

Physical Therapy Goals/Expectations:

Is there anything you feel BodyBenders should know that has not been asked? If yes, please explain:

I, the undersigned, do hereby certify that I have understood and completed the above information and know it to be truthful and accurate to the best of my knowledge. I grant permission for designated personnel of BodyBenders to provide services for my child. This agreement will remain in effect until revoked by me in writing. A photocopy, scanned image, or facsimile of this document is to be considered as valid as an original. I understand that I am responsible for full payment of all services rendered. I have been offered the Notice of Patients' Rights and I consent to physical therapy for my child. I have read and agree to BodyBenders' Policies and Procedures.

Parent/Guardian Signature:

Date: