Pilates
YOGA & PHYSICAL THERAPY

PHYSICAL THERAPY NEW CLIENT FORM

Date: _____

Name: _____ Age:_____ ☐ Male ☐ Female

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip Code:_____ Height:_____ Weight:_____

Home Phone :_____ Cell Number: _____

Occupation: _____ Email: _____

1. Describe your problem: (why you came to therapy)

2. What date was your problem first noticed? _____

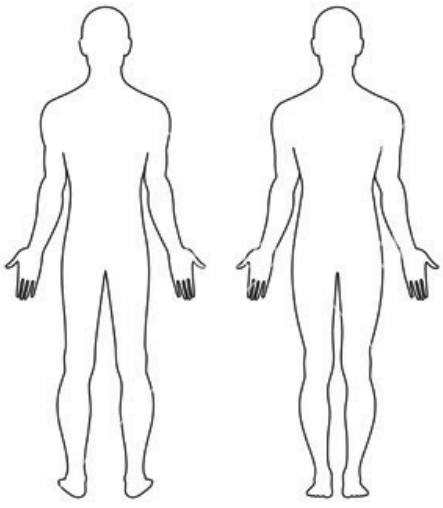
3. Do you have tingling? ☐ Yes ☐ No
   `Where?_____

4. Do you have numbness? ☐ Yes ☐ No
   Where?_____

5. What make your problem worse?
   (for example: sitting for 15 minutes, walking up stairs, looking over your shoulder when driving)

6. What improves/eases your problem?
   (for example: lying on your side)

On the image below, please shade in the areas which are painful or problematic.



7. Does your problem disturb your sleep? ☐ Yes ☐ No If so, how often do you wake up at night? _____

   How is your problem first thing in the morning? ☐ worse ☐ better ☐ same

   How is your problem at the end of the day? ☐ worse ☐ better ☐ same

7008 Bishop Rd. • Suite 1101 • Plano TX 75024 | 201 S. Main Street • Suite C • Prosper TX, 75078
214-563-0307 | info@dpilates.com | dpilates.com | prosperphysicaltherapy.com

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HEALTH HISTORY QUESTIONNAIRE

8. What caused your problem? ☐ no reason ☐ reason (injury, exercise) please explain:

_____

9. What treatment(s) have you had for this problem thus far?

_____

What made it better? _____

What made it worse? _____

10. Is your problem getting: ☐ worse ☐ better ☐ same

11. Personal History:

What medications are you taking? _____

Do you exercise regularly? ☐ yes ☐ no Amount (hours per week)_____

Type of exercise/leisure activities: _____

Do you smoke? ☐ yes ☐ no How often?_____ Drink Alcohol? ☐ yes ☐ no Amount _____

Eating habits (vegtarian, etc.) _____

12. Have you ever had any of the following conditions?

☐ Rheumatoid Arthritis	☐ Diabetes	☐ Epilepsy	☐ Recent weight loss
☐ Hypertension	☐ Cancer	☐ Dizziness	☐ Recent weight gain
☐ Heart Problems	☐ HIV	☐ Asthma	☐ Pregnancy

13 . Please list major illnesses / surgeries / injuries:

1 _____ Date:_____

2 _____ Date:_____

3 _____ Date:_____

4 _____ Date:_____

5 _____ Date:_____

14. Are you currently working? ☐ yes ☐ no If not, when did stop working? _____

15. What activities are your currently not participating in because of this problem?

_____

16. Is there litigation (legal counseling) involved? ☐ yes ☐ no

NAME;_____

CONSENT, ASSIGNMENT, RELEASE & FINANCIAL POLICY

I, the undersigned, hereby agree and give my consent for d'Pilates Yoga & Physical Therapy to furnish care and treatment considered necessary and proper in treating my condition(s). I also certify that I (or my dependent) have insurance coverage and assign directly to d'Pilates insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid or covered by insurance. I further do hereby authorize the center to release any and all information in my chart if requested by my carrier, to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also fully understand that all co-payments and/or co-insurance payments are payable at the time of service. If I have utilized my benefits entirely, I agree to pay in full upon each visit, unless special arrangements have been made with the staff of d'Pilates, and that failure to do so can result in my account being turned over to collections and termination of my treatment.

_____ _____ _____
Parent / Guardian Relationshp to Patient Date

CANCELLATION POLICY

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment time, please give us at least 24 hours notice so that we may reschedule your appointment.

There will be a charge of $50 for NO SHOW appointments or cancellations with less than 24-hours notification. You agree that you will be personally responsible for any cancellation fees.

_____ _____ _____
Parent / Guardian Relationshp to Patient Date

RETURN CHECK POLICY (NSF)

In the event the bank returns your check due to non-sufficient funds, our office will automatically charge $25 to your account per attempt to cash your checks in addition to the amount due for the services you received. I have read and fully understand the above-referenced policies and do hereby agree to comply as specified.

_____ _____ _____
Parent / Guardian Relationshp to Patient Date

_____ _____
Witness (Staff Signature) Date

CLIENT PAYMENT AUTHORIZATION

Name: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Service Policy

All classes/appointments are subject to a 24 hour cancellation rule. Any class/appointment not cancelled before 24 hours of the scheduled time will be charged the full service rate. The studio will not charge due to cancellations for severe weather. All classes/appointments must be prepaid. Classes/appointments and reoccurring classes/appointments cannot be held without payment. This includes leaving for vacation or other extended absences. If you would like us to hold your class/appointment time(s), you must prepay for the scheduling: _____ (initial)

There are no refunds on unused services and gift certificates. All reserved classes/appointments expire three (3) months from the purchase/reservation date: _____ (initial)

Payment Amount: _____ ☐ One Time ☐ Cash ☐ Check ☐ Monthly (ahead)

Begin Payments On: _____ End Payments On: _____

Card Type: ☐ Credit ☐ Debit ☐ AMEX ☐ Discover ☐ Master Card ☐ VISA

Card Number: _____ Exp. Date:_____ CVC Code: _____

Name and Address of Card Holder

Name (as it appears on card):_____

Billing Address:_____

City: _____ State: _____ Zip: _____

I authorize d'Pilates to automatically charge each session fee per the d'Pilates billing Policies. Should I request and obtain additional services from d'Pilates, I authorize the charges associated with those services to be submitted for payment via my Card noted above. I acknowledge that I have received a copy and agree with the d'Pilates policies concerning:

☐ Waiver of Liability, Indemnity Agreement

☐ Session Cancellation

_____ _____

Client Signature Date

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