

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

Patient Registration

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Email: \_\_\_\_\_

Full Address: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell: \_\_\_\_\_ Occupation \_\_\_\_\_

Emerg. contact and phone: \_\_\_\_\_ Relationship to pt. \_\_\_\_\_

Referring Practitioner: \_\_\_\_\_ Location \_\_\_\_\_

How did you hear about QUANTUM? \_\_\_\_\_

**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”, a receipt to submit to their insurance provider for reimbursement. Quantum 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 \_\_\_\_\_

This is a very thorough questionnaire asking very important questions for our evaluation process. Please fill this out as completely as possible to provide us with a clear picture of your present symptoms, abilities and goals.

### Medical History Disclosure Form

Name: \_\_\_\_\_

1. What is the primary complaint that brings you to Quantum PT & Wellness?
  - a) When did your symptoms first appear? Have you had it before this occurrence?
  - b) Have you ever been treated for this/these problem(s) before? When, what, where, by who, for how long?
  - c) Did prior treatment successfully manage or resolve the problem at that time?  
Y/N/partial – please
  - d) How did your symptoms begin? ie. after an accident, injury, physical or emotional trauma, or without reason?
  - e) Is it the SAME, BETTER or WORSE since onset? Circle one
2. Secondary complaint? Summarize above questions here.
3. On a 10 point scale, indicate the average **intensity** of your symptoms  
0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ 6 \_\_\_ 7 \_\_\_ 8 \_\_\_ 9 \_\_\_ 10\_\_ worst
4. On a 10 point scale, indicate your **best** and **worst** level of intensity in past week.  
0 \_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ 6 \_\_\_ 7 \_\_\_ 8 \_\_\_ 9 \_\_\_ 10\_\_ worst
5. Please mark the line below to indicate the **frequency** of your symptoms.  
Never \_\_\_\_\_ Constant

6. On the lines below, place a mark to indicate your daily functional ability as a percentage of normal.

On a “good day” 0% \_\_\_\_\_ 100%  
 On a “bad day” 0% \_\_\_\_\_ 100%

7. What activities increase your pain/symptoms?

8. What activities ease your pain/symptoms?

9. For each activity listed, please note the amount of time in minutes or hours you can perform before you need to stop because of your symptoms? If time does not apply, please mark N/A, OKAY or UNABLE.

Activity	Tolerance	Activity	Tolerance
Sitting		Computer work	
Standing		Exercise	
Walking		Writing	
Stairs (# of steps/flights)		Housework	
Driving		Yardwork	
Sleeping		Reaching	
Lifting (# of lbs)		Carrying	
Other		(For Pelvic PT patients) Sexual Intercourse, pelvic exams, tampon use, voiding, sitting	

10. **What are your functional goals for this treatment program?** What activities from above would you like to be able to perform/tolerate, and for how long? ie: Be able to walk for 3 miles without pain in order to maintain exercise program. ie: be able to sleep for 5 hours without waking up due to symptoms.

- 1.
- 2.
- 3.
- 4.
- 5.

11. Place a / in front of each item that you experience **atleast monthly**. Place an **X** in front of anything you experience **more frequently** than that.

Headache	Teeth grinding <input type="checkbox"/>	Trembling
Heart racing <input type="checkbox"/>	Difficulty sleeping <input type="checkbox"/>	Skin Rashes
Irregular heartbeat <input type="checkbox"/>	Excess fatigue <input type="checkbox"/>	Water retention <input type="checkbox"/>
Chest pain, tightness <input type="checkbox"/>	Faint/dizzy <input type="checkbox"/>	Frequent urination <input type="checkbox"/>
Numbness, Tingling <input type="checkbox"/>	Tense/nervous <input type="checkbox"/>	Incomplete urination <input type="checkbox"/>
Cold hands/feet <input type="checkbox"/>	High personal stress <input type="checkbox"/>	Painful urination <input type="checkbox"/>
Coughing <input type="checkbox"/>	Constant anxiety <input type="checkbox"/>	Urinary leakage <input type="checkbox"/>
Sinus congestion <input type="checkbox"/>	Thoughts of suicide <input type="checkbox"/>	Bowel irregular <input type="checkbox"/>
Earache, ringing <input type="checkbox"/>	Hopelessness <input type="checkbox"/>	Constipation <input type="checkbox"/>
Asthma <input type="checkbox"/>	Feeling overwhelmed <input type="checkbox"/>	Unable to have sex <input type="checkbox"/>
Sore,aching muscles <input type="checkbox"/>	Blurred vision <input type="checkbox"/>	Severe menstrual cramps <input type="checkbox"/>
Stiff,tender joints <input type="checkbox"/>	Stomach cramps <input type="checkbox"/>	Fibrotic breasts <input type="checkbox"/>
Allergies <input type="checkbox"/>	Acid reflux <input type="checkbox"/>	
Back problems <input type="checkbox"/>	Naseau/vomitting <input type="checkbox"/>	

12. 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? \_\_\_\_\_

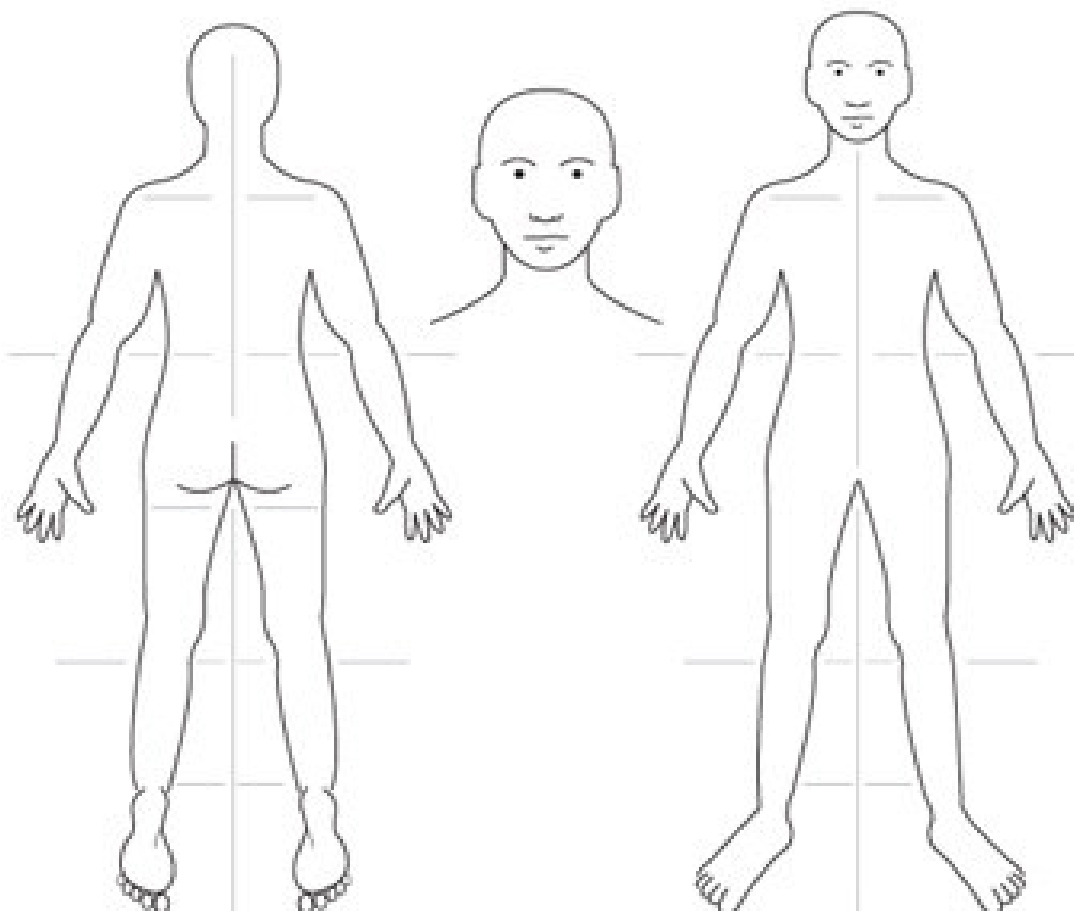
Are you pregnant or is there a possibility that you are? \_\_\_\_\_

13. **MEDICATIONS:** Please indicate below ALL medications you are currently taking, the problem for which you are using them for, dosage, and effectiveness.

Medication	Treatment for	Dose/Amt/Day	Effectiveness

**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 shade in areas of pain or symptoms.  
Rate those areas 1-10 based on severity.**

## **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. Quantum charges \$50 for all cancellations made within 24 hours prior to your scheduled appointment time. **This applies to all cancellations regardless of cause.**
3. Your credit card on file will be charged at the time of cancellation. Otherwise, you will receive an invoice for the cancellation fee of \$50.

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 Quantum. If I have any questions regarding this policy, I have clarified them with 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 Quantum, 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 \_\_\_\_\_