ALTERNATIVE PHYSICAL THERAPY

JERA RATLIFF, PT, CPT, CFMT

OFFICE
10801 Thornmint Road, Ste 250
San Diego, CA 92127

PHONE
858-254-8684

WEB
www.thealternativept.com

Thank you for choosing Alternative Physical Therapy!
Please take the time to fill out the forms in this packet completely and bring with you to your first appointment so we can maximize the time spent with the physical therapist.

On the day of your appointment, please bring:

- Completed Forms located in this packet
  - Client Information Form
  - Medical History / Screening Form
  - Consent to Evaluation and Treatment
- Doctor Referral Slip - May have been done electronically for you
- Any critical MRI or surgical reports (this event includes old reports if you have them)
- Comfortable clothing - Please wear something loose (or bring it with you). Comfort is key, and an elastic waistband works best. A tank top preferred (ladies), and make sure to bring a sweater to keep warm.

What to Expect: The first visit is an in-depth interview regarding your problems, a review of your history, a physical therapy assessment and usually a first treatment session. The entire process is critical as it provides the key insights into unlocking the mystery of your problem, and will allow further assessment the following visit based on how your body responded. All evaluations are at least one (1) hour. Follow-up appointments can vary from thirty (30) to sixty (60) minutes, based on individual needs.

Directions: From the I-15: Take the I-15 North to Exit 22 for Camino Del Norte. Turn LEFT onto Camino Del Norte. Then turn RIGHT on Camino San Bernardo. At the second light, turn RIGHT on Thornmint Road. Our building will be the first on the RIGHT. Turn into the driveway, then turn RIGHT to proceed to the last building, 10801 Thornmint Road.

Parking: Free parking located in the lot around the perimeter of the building. You can park in any of the spaces that are not reserved. Handicap parking is available.

We look forward to seeing you! Please feel free to call our office if you have any questions at 858-254-8684.

ALTERNATIVE
PHYSICAL THERAPY

Jera Ratliff, PT, DPT, CFMT
CA # 13757
10801 Thornmint Road, Suite 250, San Diego, CA 92127
Office: 858-254-8684 Fax: 858-408-2613

Patient Information

Last Name:	First Name:	M.I.:	Today's Date:

Mailing Address: City/State/Zip:

Home Phone: Cell Phone: Work Phone w/ Ext:

Email Address: Date of Birth: Sex: ☐ Male ☐ Female

Employer: Occupation:

Referring Practitioner/Doctor: Office Phone:

Emergency Contact: Phone: Relationship to Patient:

Who may we thank for your referral?

Please list all SURGERIES (in order by year)		Please list all TRAUMAS (in order by year)	
Year	Surgery / Purpose	Year	Incident

(Use back of page to continue)

Physical Goal & Function

What are your goals as a result of physical therapy?

What is your current (percentage) level of function? _____ %

How would you assess your overall state of health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Superb

Do you exercise? ☐ Yes ☐ No Type/s of Excercise:

Rate your overall activity level: ☐ Sedentary ☐ Mildly Active ☐ Moderately Active ☐ Very Active ☐ Athletic

ALTERNATIVE PHYSICAL THERAPY

Jera Ratliff, PT, DPT, CFMT
CA # 13757

10801 Thornmint Road, Suite 250, San Diego, CA 92127
Office: 858-254-8684 Fax: 858-408-2613

MEDICAL HISTORY/SCREENING FORM

Last Name:	First Name:	Date:	Re-admit date:

PLEASE INDICATE THE FOLLOWING MEDICAL INFORMATION
Fill in or add notes on back of page if needed

CARDIAC

- ☐ Chest Pains / Angina
- ☐ Heart Attack
- ☐ Dizziness with Exertion
- ☐ Stroke or Transient Ischemic Attacks (TIAs)
- ☐ Artial Fibrillation ☐ Taking Medication?
- ☐ Cardiac Surgery: _____
- ☐ Peripheral Vascular Compromise
- ☐ History of blood clot(s)

PULMONARY

- ☐ Shortness of Breath (Past 6 Months)
- ☐ Tuberculosis
- ☐ Emphysema or Asthma or Other COPD
- ☐ History of Smoking: Years ___ Quit? YES / NO
- ☐ Pneumothorax

NEUROLOGICAL

- ☐ Migraines: Years ____
- ☐ Seizures: Type: _____Frequency _____
- ☐ Concussion(s) *See previous page for traumas*
- ☐ Polio or Muscle Disease
- ☐ Multiple Sclerosis or Parkinson Disease
- ☐ Traumatic Brain Injury
- ☐ Tinnitus: Years _____
- ☐ Neuropathy: Where? _____

GASTRO-INTESTINAL DISORDERS

- ☐ Reflux (GERD)
- ☐ Hiatal Hernia
- ☐ Ulcer(s)
- ☐ Gall Bladder Disease
- ☐ Irritable Bowel Syndrome
- ☐ Constipation or Diarrhea
- ☐ Nausea or Vomiting
- ☐ Bowel Incontinence
- ☐ Hepatitis: (circle one: Type A, B, or C)
- ☐ History of Eating Disorder

URINARY

- ☐ Incontinence: Stress OR Urge
- ☐ Frequent Infections
- ☐ Prostate Problems: _____
- ☐ Difficulty Urinating
- ☐ Kidney Issues or History of Infection

BONE & JOINT & MUSCLE

- ☐ Osteo-penia or Osteo-porosis
- ☐ Osteo-arthritis or Rheumatoid Arthritis
- ☐ Artificial Joints: _____
- ☐ Fractures: _____
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Other Spinal Disorder
- ☐ Foot / Toes
- ☐ Other Joint: _____
- ☐ Muscle Injuries: _____

GYNECOLOGICAL

- ☐ Pregnant (or chance of pregnancy) _____ Weeks
- ☐ Births? Vaginal _____ C-Section _____
- ☐ Ovarian Cysts or Uterine Fibroids
- ☐ Pelvic Pain (other)
- ☐ Endometriosis

OTHER

- ☐ Cancer: Year/Type _____
- ☐ Any unlisted Auto-Immune Disease _____
- ☐ Fibromyalgia
- ☐ Diabetes: Type 1 OR 2 Controlled? YES / NO
- ☐ Hypoglycemia
- ☐ Allergies: _____
- ☐ Anemia
- ☐ Blood Disorder
- ☐ Anxiety: Mild or Moderate or Severe
- ☐ Depression: Controlled? YES / NO
- ☐ HIV: YES / NO / Do Not Wish to Answer
- ☐ Bleeding Disorder
- ☐ ANY current contagious disease? _____
- ☐ SKIN problems: _____

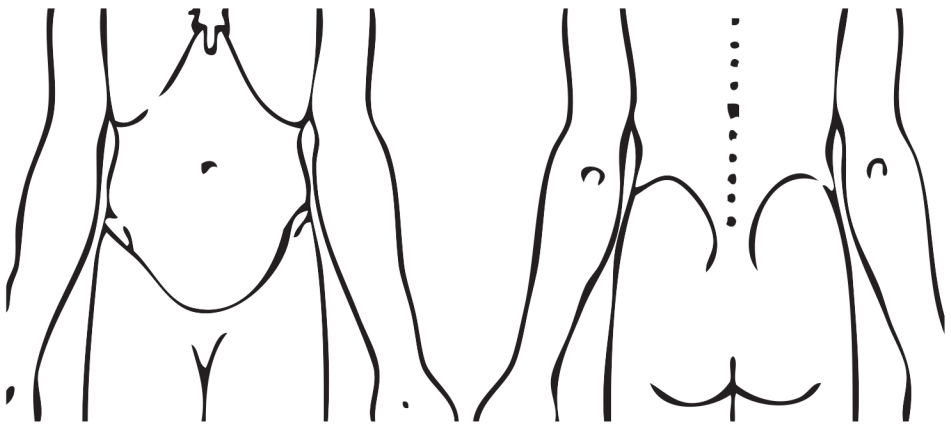
CURRENT MEDICATIONS (and reason IF known: i.e. *Glucophage - Diabetes).* If MEDICARE, stop and complete the FULL FORM!

_____
_____
_____
_____
_____

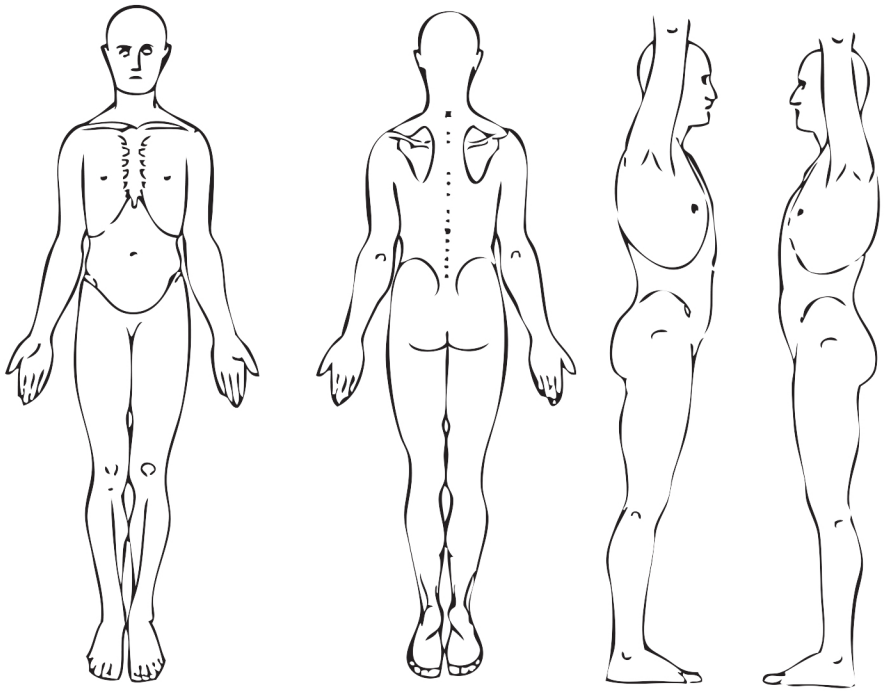
PATIENT'S SIGNATURE: _____

Circle the location of your pain and label with the pain range (0 to 10) in the past month:

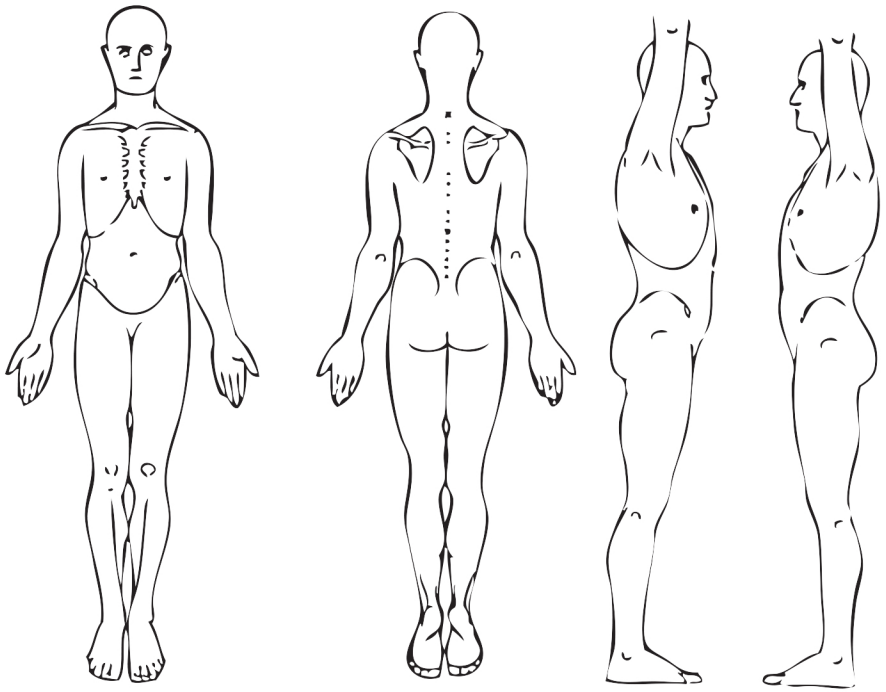
(1) Abdomen Pain Only



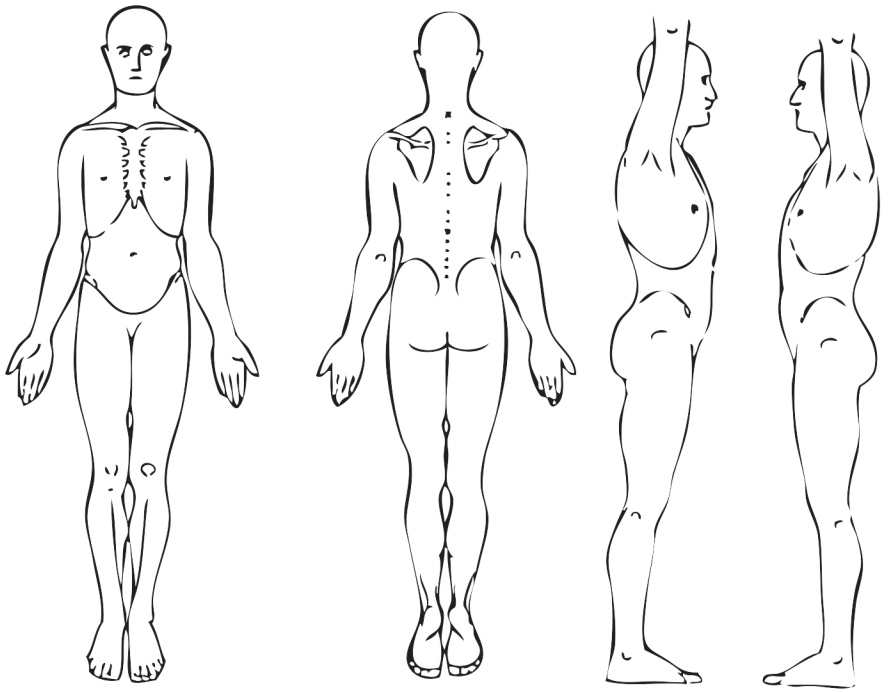
(1) Surgical Scars Only



(3) Pain Felt in the Past Month



(4) Current Pain



ALTERNATIVE PHYSICAL THERAPY

Jera Ratliff, PT, DPT, CFMT
CA #13757
10801 Thornmin Road, Suite 250, San Diego, CA 92127
Office: 858-254-8684 Fax: 858-408-2613

CONSENT TO EVALUATION & TREATMENT

I do hereby consent to the evaluation and treatment by Alternative Physical Therapy. I understand it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment. **Initial Here** _____

RELEASE OF INFORMATION

I authorize Alternative Physical Therapy to release information for my medical record, whether it be written, video, photographic, audio, or verbal to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with the custodian of records. I consent to the use of non-peronally identifying information from my medical record for the purpose of outcome analysis. I consent to the release of my medical information to and from my (Doctor) _____, (Insurance Company) _____, and (Family Members) _____ for communication and care coordination on my behalf.

PRIVACY PRACTICES

I acknowledge I have read the HIPPA Privacy Practice prior to this admission or have requested a copy to do so.
Initial Here _____

PREFERRED METHOD OF COMMUNICATION OF HEALTH INFORMATION

Alternative Physical Therapy is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by Alternative Physical Therapy. Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination notes, our assessment of your condition, a record of your treatment interventions and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances.

Please initial next to your preferred method of communication for any/all health information sent to you:
_____ Email
_____ Mobile Phone (call/text)
_____ Home Phone
_____ Other: _____

TREATMENT FOR DIRECT ACCESS PATIENTS

Direct Access in the state of California began January 2014. The law states that you can see a licensed physical therapist without seeing a doctor for a referral, but only for either up to 45 calendar days or 12 visits; whichever comes first. If you require treatment beyond these guidelines, you will be asked to comply by getting a referral from your physician or surgeon. Physical therapy can be continued only after a referral is obtained by or sent to Alternative Physical Therapy.
Initial Here _____

CANCELLATION POLICY

The undersigned is aware and agrees, whether signing as an agent or patient, to an out of pocket fee up to $50 for each scheduled appointment that is either missed without notice or cancelled after 4 pm the day prior to your appointment*. Alternative Physical Therapy requires 24 hour notice for cancelled appointments.*If appointment is on a Monday, please leave a voicemail at 858-254-884 before 4 pm on Sunday.

The undersigned certifies that s/he has read, understood, and accepts the terms of this form, received a copy (if desired) and is the patient or is duly authorized by the patient as the patient's general agent to execute this form

_____ _____ _____
Signature of Patient or Responsible Party Print Name Date