



WHITE SANDS PHYSICAL THERAPY & AQUATICS

MEDICAL HISTORY

Patient Last Name: _____ **First Name:** _____ **DOB:** _____

Primary Care Physician: _____

Referring Physician or name of the doctor who will be signing any reports generated by your therapist: _____

Diagnosis or reason for Physical or Occupational Therapy _____

Check all current or past conditions:

Back Pain	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Tingling in Legs/Feet	<input type="checkbox"/>
Spinal Stenosis	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	Total Knee Replacement	<input type="checkbox"/> L <input type="checkbox"/> R
Back Surgery	<input type="checkbox"/>	Balance	<input type="checkbox"/>	Total Shoulder Replacement	<input type="checkbox"/> L <input type="checkbox"/> R
Disc Problems	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	Total Hip Replacement	<input type="checkbox"/> L <input type="checkbox"/> R
History of Sciatica	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Cancer: Type _____	<input type="checkbox"/>
History of Scoliosis	<input type="checkbox"/>	COPD	<input type="checkbox"/>	Fear of swimming pool	<input type="checkbox"/>
Knee Pain	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Open Wound/Sore	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Skin Rashes	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Osteoarthritis (Degenerative)	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	Memories Issues	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>
Neck Stiffness	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Alzheimer	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	Diabetes	Type 1 <input type="checkbox"/>	Anemia	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>		Type 2 <input type="checkbox"/>		
Pacemaker / Defibrillator	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	Infection Disease	<input type="checkbox"/>
CVA Stroke	<input type="checkbox"/>	Thyroid	Hypo <input type="checkbox"/> Hyper <input type="checkbox"/>	Vision Problems	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Bladder Urgency	<input type="checkbox"/>	DNR	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	Bladder Incontinence	<input type="checkbox"/>	Metal Implant	<input type="checkbox"/>
Parkinson	<input type="checkbox"/>	Bowel Urgency	<input type="checkbox"/>		
Headaches	<input type="checkbox"/>	Bowel Incontinence	<input type="checkbox"/>		
Epilepsy or Seizure	<input type="checkbox"/>	Peripheral Neuropathy	<input type="checkbox"/>		
Dizziness/Fainting	<input type="checkbox"/>	Tingling in Arms/Hands	<input type="checkbox"/>		
Falls (last fall date)	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>		



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Patient Last Name: _____ **First Name:** _____ **DOB:** _____

Do you live alone? Yes No Living partner disabled? Yes No

Do you smoke or use other Tobacco Products? Yes No

Height: _____ Feet _____ Inches

Weight: _____ Pounds

We recommend that you consult with your general practitioner about any weight management question. **Patients Initials:** _____

SURGERIES: Please list with Date and Details:

OTHER HEALTH ISSUES (Including Chronic Conditions):

Please list: _____

ALLERGIES:

Please list: _____

- I have listed all my medical conditions to the best of my knowledge.
- I attest that the information provided by me on this medical history form is correct.

Patient Signature

Date

WHITE SANDS PHYSICAL THERAPY & AQUATICS

MEDICATIONS LIST

Patient Last Name: _____ **First Name:** _____ **DOB:** _____

Please provide us with a complete list of your medications for our files. Please include any Over the Counter medications, Vitamins or Herbal Supplements you may be taking. If you need a second page, please let us know.

Please also list any OTC pain or anti-inflammatory medications even if only taken as needed. (ie: Tylenol, Advil, Motrin, Aleve, etc)

	Prescription/Over the Counter/Vitamins Supplements/Herbal Supplements	Dosage	O - Oral I - Injection C - Cream S - Sublingual	Times per day. If only used as needed circle PRN	What is it used for? (i.e.: heart, Blood pressure, kidney)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Check if apply:

- I am currently not using any medications.
- Please see my list of medications provided on separate page.
- I verify that the above list of medications/Supplements is correct and contains all that I am currently taking.

Patient Signature

Date

WHITE SANDS PHYSICAL THERAPY & AQUATICS

PATIENT DEMOGRAPHICS

PATIENT INFORMATION (Please Print)

Patient Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security #: _____ Gender: Male Female

Home Phone: _____ Other Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Out of State Address & Phone #: _____

EMERGENCY CONTACT

Name: _____ Home/Cell Phone: _____

Relationship: _____

Electronic Communication:

White Sands Physical Therapy & Aquatics believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from White Sands Physical Therapy & Aquatics via email or text messaging. White Sands Physical Therapy & Aquatics does not share the names, e-mail addresses, and/or telephone numbers of patients with any other company, or with any other patient.

Email: _____ Cell Phone: _____

Authorization to discuss your care with Family or Friends

White Sands Physical Therapy & Aquatics is authorized to discuss health, appointment and/or billing information pertaining to the above patient to the entities below.

- Leave information on voice mail: Home Cell Work
- Share information to _____ Relationship: _____
- Share information to: _____ Relationship: _____

White Sands Physical Therapy will bill your insurance as a courtesy to you; however, if no payment is received from your insurance within 45 days of billing, payment in full will be expected from you. I hereby authorize my benefits, including Medicare, to be paid directly to White Sands Physical Therapy and authorize the release of medical information necessary to process claims.

Patient Signature

Date

Staff Initials: _____
Rev. 01.04.22

7157 Curtiss Ave.
Sarasota, FL 34231

I reviewed the information and made any necessary changes.

WHITE SANDS PHYSICAL THERAPY & AQUATICS

Patient Last Name: _____ First Name: _____ DOB: _____

PHYSICIAN

Date of Next Appointment with Referring Physician: _____

Have you received any physical, occupational or speech therapy in this calendar year? Yes No

How many visits: _____ Place of service: _____ Date of last visit: _____

What area(s) of the body was treated? _____

Have you had Home Health Care in the past 60 day? Yes No How many visits: _____

Have you been Discharged? Yes No If yes, Date of Discharge: _____ Agency that provided care: _____

Please Read & Initial:

*** Medicare will not pay for Outpatient Physical Therapy if patient is receiving any type of Home Health Care. This includes Home Health Nursing, Home Health Respiratory, Home Health Aide, and/or any other type of Home Health Care. It is the patient's responsibility to inform the Therapist or office staff if the patient is currently under Home Health Care. If WSPTA is denied payment because of Home Care Services, then the patient is responsible for the full cost of care provided by WSPTA.** Patients Initials: _____

*** Patient that are scheduled to go in the pool, please be aware, NO OPEN WOUNDS IN THE WATER. If you are to have a biopsy done you will not be able to go into the pool for two weeks after having a biopsy and a written release from your MD will be required to resume pool treatment. We request that for your benefit, all biopsies be scheduled after you have completed therapy (unless otherwise noted by your doctor).** Patients Initials: _____

*** WSPTA strives to provide the best therapy in the area, any changes in your health while enrolled in our program makes a difference in your care. Please report any falls or injury immediately, your therapist will need to evaluate your condition to make sure that is safe to continue treatment. In the case of a serious injury or fall, a Doctor's note may be required to resume treatment.** Patients Initials: _____

***Health disclaimer: I attest that as of today, I am not experiencing any symptoms of illness suggesting a Cold, flu or Covid-19 infection. I acknowledge White Sands Physical Therapy and Aquatics efforts in keeping the patients and staff safe by following and implementing CDC guidelines. I will promptly inform White Sands Physical Therapy and Aquatics if I become ill or come in contact with someone sick or positive for Covid-19, or if I myself, test positive for COVID-19.** Patients Initials: _____

ACCIDENT: Are your symptoms related to an accident? Yes No

Auto Accident? Yes No

Work Related Accident: Yes No

Accident Date: _____ Claim No.: _____

Adjuster Name: _____ Phone No.: _____

Is the Case Settled? Yes No **Is there or will there be a legal matter in this case?** Yes No

If yes: Attorney: _____ Phone No.: _____

I attest that the information provided by me on this patient information form is correct.

Patient Signature

Date

Staff Initials: _____
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Sarasota, FL 34231



WHITE SANDS PHYSICAL THERAPY & AQUATICS

Patient Last Name: _____ First Name: _____ DOB: _____

Acknowledge of Receipt of Notice of Privacy Practices

I have received or have been offered a copy of the Notice of Privacy Practices from White Sands Physical Therapy & Aquatics.

Patient Signature

Date

Authorization for treatment, Acknowledgement of Financial Responsibility and Assignment of Benefits

I acknowledge that I am legally responsible for all charges in connection with the medical care, treatment and therapy provided by representatives and personnel of White Sand Physical Therapy & Aquatics, LLC. I consent to the release of any medical information, including diagnosis and the records of any treatment or examination rendered to me for such services to third party payers, health care practitioners and/or managed care organizations. I hereby assign, authorize, and direct payment of my medical benefits to White Sands Physical Therapy & Aquatics, LLC. I understand that White Sands Physical Therapy & Aquatics, LLC will assist me in submitting my claims to my insurance carrier. I understand my insurance carrier may not approve or reimburse my medical services in full due to benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. Furthermore, any information given to us may be used for the collection of payments for services provided.

Patient Signature

Date

NO SHOW AND CANCELLATION POLICY

An appointment with a White Sands Physical Therapy and Aquatics therapist reserves a period of time for you. A cancelled appointment or a no show keeps others from having access to that therapist.

- + We require at least 24 hours' notice of cancellation in advance of your scheduled appointment.
- + All no shows and late cancellations for appointments will be charged \$50.00 for any missed appointment (that includes any portion of your treatment cancelled at the last minute).
- + Please cross check your White Sands schedule against your calendar at home for any conflict that would result in a cancellation fee.
- + This fee must be paid prior to receiving future services.
- + Chronic Cancellations will cause to cancel all patients schedule.
- + Medical insurance cannot be billed for missed appointments.
- + I understand that I must call to cancel my appointment 24 hours prior to my scheduled appointment time. **There will be a \$50.00 No call/No show fee assessed when notification is not given for a missed appointment without 24 hours' notice.**

I have read, understand, and agree with the provision of this cancellation policy.

Patient Signature

Date

WHITE SANDS PHYSICAL THERAPY & AQUATICS

Patient Last Name: _____ First Name: _____ DOB: _____

Geriatric Depression Scale

Please circle **YES** or **NO**. Circle the best answer for how you have felt over the past week:

1	Are you basically satisfied with your life?	Yes	No
2	Have you dropped many of your activities and interests?	Yes	No
3	Do you feel your life is empty?	Yes	No
4	Do you often get bored?	Yes	No
5	Are you in good spirits most of the time?	Yes	No
6	Are you afraid that something bad is going to happen to you?	Yes	No
7	Do you feel happy most of the time?	Yes	No
8	Do you often feel helpless?	Yes	No
9	Do you prefer to stay at home, rather than going out and doing new things?	Yes	No
10	Do you feel you have more problems with memory than most?	Yes	No
11	Do you think it is wonderful to be alive now?	Yes	No
12	Do you feel pretty worthless the way you are now?	Yes	No
13	Do you feel full of energy?	Yes	No
14	Do you feel that your situation is hopeless?	Yes	No
15	Do you feel that most people are better off than you are?	Yes	No

Elder Abuse Suspicion Index

Please circle **YES** or **NO**. You do not have to answer these questions if you do not want to.

1	Do you rely on people for any of the following: bathing, dressing, shopping, banking, or meals?	Yes	No
2	Has anyone prevented you from getting: food, clothes, medication, glasses, hearing aids medical care, or from being with people you wanted to be with?	Yes	No
3	Have you been upset because someone talk to you in a way that made you feel shamed or threatened?	Yes	No
4	Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No
5	Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No

Patient Name: _____

(Please Print)

Patient Signature: _____

Patient refused to fill out in part or in full _____

Staff Initials: _____

Staff Initials: _____
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