



THE NATE WATERS
PHYSICAL THERAPY CLINIC
AT TULSA COMMUNITY COLLEGE

Application Form

Name: _____ First _____ Last

Male/Female Married/Single/Other DOB: _____

Home Address: _____ City _____ State _____ Zip _____

Phone(Personal) _____ Phone(work) _____ e-mail _____

How would you like for us to contact you? Phone Call Text Message e-mail

If you would like to be contacted by text message please list your cell phone number: _____

Emergency Contact _____ Relationship _____

Phone _____ Other Means of Contact _____

What are your concerns or reasons for visiting our clinic? What are your treatment goals?

Do you have a physician referral in hand? yes no

Do you have a primary care physician? _____

Physician's Practice Name or Group: _____

Physician Phone Number _____ Address _____

How did you find out about the Nate Waters Physical Therapy Clinic? Who referred you to the clinic? _____

Health History

How would you rate your health over all? Excellent Very Good Good Fair Poor

Have you been hospitalized in the past 6 months to year? No Yes, if yes please explain:

Have you had Physical Therapy in the past year? No Yes, If yes please why and where did you receive services?

Are you currently employed or going to school? No Yes, If so where and in what capacity?

Are you allergic to anything? No Yes, If yes please list: (You may use the back if needed)

Have you had any surgeries? No Yes, If yes please list and give a date of when the surgery occurred:

Do you take any prescribed medications? No Yes, If yes please list:

Do you have take any over the counter medications, vitamins or supplements? No Yes, if so what:

Past Medical History (Check all that apply)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> MRSA | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Internal Pacemaker | <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heartburn/Gastric Reflux |
| <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Kidney dialysis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Bruising | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Seizures | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Artificial Joint <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Metal implants | <input type="checkbox"/> Infusion Pump (indwelling) |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Vitamin Deficiency | |
| <input type="checkbox"/> Cancer, if so what type? _____ | | | |
| <input type="checkbox"/> Other _____ | | | |
-

CONSENT TO TREATMENT: I consent to services at the Nate Waters Physical Therapy Clinic at Tulsa Community College. In so doing I understand that services will have an educational objective and that students will be involved in the service delivery. I also understand that services may involve bodily contact, touching and/or direct contact which may seem to be of sensitive nature but that my comfort and modesty will be addressed at all times. I understand that I have the right to refuse and withdraw from service provision at any time.

Initials

TREATMENT OF MINORS: I, as a parent or legal guardian give consent to services as directed by the Physical Therapist upon being informed of such services as listed in the recorded plan of care. I understand that I shall be on premises at all times and will cooperate fully with the students, staff, faculty and practitioners of the Nate Waters Physical Therapy Clinic.

Initials

LIABILITY: I know and agree that the Nate Waters Physical Therapy Clinic at Tulsa Community College is not responsible for lost/damaged personal items.

Initials

WAIVER AND RELEASE: I hereby release, discharge and acquit the Nate Waters Physical Therapy Clinic at Tulsa Community College, it's agents, representatives, affiliates, employees or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

Initials

NOTICE OF PRIVACY PRACTICES: I hereby assign all benefits directly to the Nate Waters Physical Therapy Clinic at Tulsa Community College and authorize release of any medical records necessary to facilitate my treatment process. I have been given information regarding HIPAA, in regard to confidentiality and use of my personal health information.

Initials

I certify that all information provided here is true and correct.

Patient/Guardian

Witness