



MEDICAL INFORMATION

Have you ever had any of the following? (Please check ALL that apply)

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Mental condition |
| <input type="checkbox"/> Asthma / difficulty breathing | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Night pain |
| <input type="checkbox"/> Depression / Anxiety | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes or hypo/hyperglycemia | <input type="checkbox"/> Osteoarthritis or Rheumatoid arthritis |
| <input type="checkbox"/> Dizziness / Vertigo | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Fracture or Suspected Fracture | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Headaches / injury to head | <input type="checkbox"/> Swelling / joint pain |
| <input type="checkbox"/> Heart condition / pacemaker | <input type="checkbox"/> Vision / hearing problems |
| <input type="checkbox"/> High / low blood pressure | <input type="checkbox"/> Surgeries: _____ |
| <input type="checkbox"/> Lung disorders | <input type="checkbox"/> Other: _____ |
- Use of tobacco? Yes No In the past Any recent unexplained weight loss? Yes No
- Are you currently pregnant? Yes No Falls in past year? Yes No How many: _____
-

CURRENT CONDITION

What are you being treated for? _____

When did it start? _____ How did it happen? _____

What makes it better? _____ What makes it worse? _____

Imaging: MRI X-Ray Other Date / Office: _____

Previous or recent surgery for this issue (type, date): _____

Have you noticed in recent changes in: Bowel/bladder Weakness Numbness

Any other pertinent information? _____

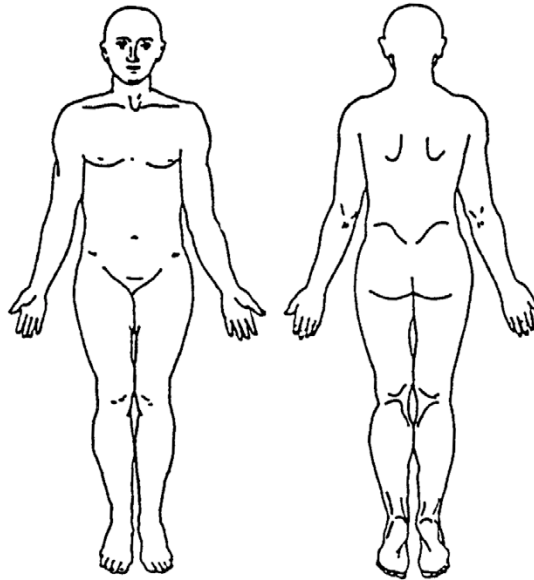
MEDICATION LIST



MEDICATION	DOSE / FREQUENCY	REASON

Please use the diagram below to indicate the symptoms you are experiencing.

A: ache S: stabbing R: radiating P: pins and needles N: numbness O: other



Please circle the severity of your pain, 0 (being no pain) 10 (being severe pain)

Current Level of Symptoms	0	1	2	3	4	5	6	7	8	9	10
Worst Level of Symptoms	0	1	2	3	4	5	6	7	8	9	10
Least Level of Symptoms	0	1	2	3	4	5	6	7	8	9	10



Payment / Card Policy:

Range Physical Therapy & Wellness requires a valid debit or credit card on file. Cards are securely stored through Jane Payments, a PCI DSS-compliant system. Staff cannot view your full card details. Range Physical Therapy & Wellness may keep this card on file and utilize this card to obtain payment for any and all charges you accrue on your account, including but not limited to: (1) fees for services provided; (2) late cancellation/no show fees; and (3) fees due at time of services (ie copays). To the extent this card ever becomes invalid, you agree to immediately provide Range PT with an updated and valid card. Your treatment may temporarily be suspended if you fail to maintain an active card on file at all times. I agree to the above Payment Policy, authorizing Range Physical Therapy & Wellness to keep my card on file and to utilize it for payment of services rendered, payments due at time of service, and/or late cancellation/no show fees.

Initial Here: _____

Text Message Communication

I consent to receiving text messages from Range Physical Therapy & Wellness at the phone number provided for purposes such as appointment reminders, scheduling updates, and care-related information. I understand this list is not exhaustive. I also understand text messaging is not a secure form of communication, and confidentiality cannot be guaranteed. I acknowledge that message and data rates may apply, and I can opt out at any time by written notice to Range Physical Therapy & Wellness.

Initial Here: _____

Cancellation / No-Show Policy

If you are unable to attend your scheduled appointment, **you must provide Range PT at least 24 hours' advance written notice by emailing info@rangeptmontana.com or calling (406) 370-1377, otherwise a \$50.00 late cancellation or no-show fee will be administered** for each occurrence and may be immediately charged to the card on file (which is not covered by insurance). You will not be able to attend future appointments until this fee is paid in full. If you late-cancel (less than 24 hours) or no show more than two times, you will be removed from the schedule. As identified herein after two occurrences, under Range's discretion, you may be asked to schedule only day-of appointments when available or discharged from our practice. We have an answering machine on 24-hours a day for you to leave a message. By initialing below, I agree to the above-Cancellation Policy.

Initial Here: _____

By signing below, I agree to all of the terms and conditions and payment requirements outlined above:



Patient or Guarantor, Printed Name

Signature

Date