James R Guzman, PT, DPT, PRC
Advanced Integrative Concepts LLC
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General Information

Today's Date: _____/_____/_____

Last Name: _____ First Name: _____ M.I: _____

Date of Birth: ___/___/____ Age: _____ Height:_____ Wt:_____ Shoe Size:_____

Address: _____City: _____ State: _____ Zip Code: _____

Cell #_____ Work #_____ Other #_____

Email: _____

Occupation: _____ Employer: _____

Marital status: single married divorced widowed Spouse's name: _____

Who should we contact in case of an emergency? _____ Tel # _____

Whom may we thank for referring you to our office?

_____

Responsible Party

Please fill out below if someone other than yourself is responsible for this account:

Name of person responsible for this account: _____Relationship to patient: _____

Address: _____City: _____ State: _____ Zip Code: _____

Cell #_____ Work #_____ Other #_____

Date of Birth: ___/___/____ Is this person currently a patient in our office? Yes o

Chief Concerns, Goals and Hopes

Please answer the questions on the lines below.

1. List and describe your problems in order of importance to you (please include when and how they started).

   _____

   _____

   _____

2. How have these problems affected your life? Does it keep you from doing anything that you want to do? (work, play, chores, eating, talking, etc.)

   _____

   _____

3. What would you hope to accomplish with treatment here?

   _____

   _____

4. Do you have any burning questions that you would like answered today?

   _____

   _____

5. What has CHANGED and WHEN:
   **So that we may have a better understanding of your problems, please list in chronological order with date estimates all the changes and/or defining moments of your problem. (Examples are fell down stairs, left TMJ clicking started, clicking stopped, teeth shifted, headaches increased, headaches stopped, left ear pain, right knee felt weak, right foot pain, etc.)

   Date Estimate Change that Occurred

_____
_____
_____
_____
_____
_____
_____
_____
_____

6. Are you currently exercising or wish to get back to exercise or sports activity?

   _____

7. Is there anything else that we should know about you?

   _____

   _____

Medical History

Have you had any of the following medical or rehabilitative services for this Injury/Episode?

	YES	NO
General Practitioner		
Postural Therapist		
Optometrist		
Neurologist		
Osteopath		
Massage Therapist		
Chiropractor		

	YES	NO
Occupational Therapy		
Physical Therapy		
Cone Beam CT		
CT Scan		
MRI		
Full Mouth X-Ray		
X-Ray		

Do you have, or have you ever had any of the following?

	YES	NO
Asthma, bronchitis, emphysema		
Shortness of breath/chest pain		
Heart attack or heart surgery		
Stroke/TIA		
Epilepsy/seizures		
Headaches		
Cancer/Chemotherapy/Radiation		

	YES	NO
Emotional/Psychological problems		
Bladder Problems		
Numbness or tingling		
Ringing in your ears		
Any pins or metal implants		
Joint replacement		
Breastfeed		

If you answered Yes, please explain below.

_____
_____
_____

Please list any current medications/vitamins/supplements that you are currently taking.

_____
_____

Please list any current allergies/drug allergies that you have.

_____
_____

Please list any accidents/surgeries that you have had. (ex. Car accidents, falls, TBI)

_____
_____
_____

On a scale from 1-10, how well do you sleep at night (1-bad, 10-best)? _____ Do you have dreams? _____

How many times do you wake up during the night? _____ Do you have to use the bathroom? _____

On a scale from 1-10, how hard is it to fall asleep at night (1-bad, 10-best)? _____

What sleep aids do you use? _____

Dental History

In the past have you had:

Broken Teeth	NO	YES; please explain:_____
Grinding of Teeth	NO	YES; please explain:_____
Crown(s)	NO	YES; how many:_____
Root canal(s)	NO	YES; how many:_____
Open or Crossbites	NO	YES; please explain:_____
Implant(s)	NO	YES; how many:_____
Missing teeth	NO	YES; how many:_____
Palatal expansion	NO	YES; treatment: _____
Orthodontics	NO	YES; how long: _____

Is there anything about your dental history that you feel is important for me to know?

_____

_____

_____

Are you currently or in the past worn a night guard or appliance?_____

TMJ Dysfunction:

Do you have headaches? _____ Location: _____Intensity: _____

Who have you seen (healthcare provider) for this condition? _____

Do you clench or grind your teeth [Bruxism]? _____

Does your tongue typically rest on the roof of your mouth? _____

Does your jaw pop or click if so, how often does this happen? _____

Do you typically breath through your mouth or nose? _____

Do you have a high & narrow palate [roof of your mouth]? _____

Do you wear any oral appliance for the TMJ? _____

Have you ever had myofunctional therapy? _____

Vision History

When was your last vision exam? _____/_____/_____ Optometrist Name: _____

Do you wear glasses? □ Yes □ No If yes, how old is your prescription? _____/_____/_____

Do you wear contact lenses? □ Yes □ No

Do you currently, or have you ever had any ocular(eye) problems? If so, please explain below and specify which eye.

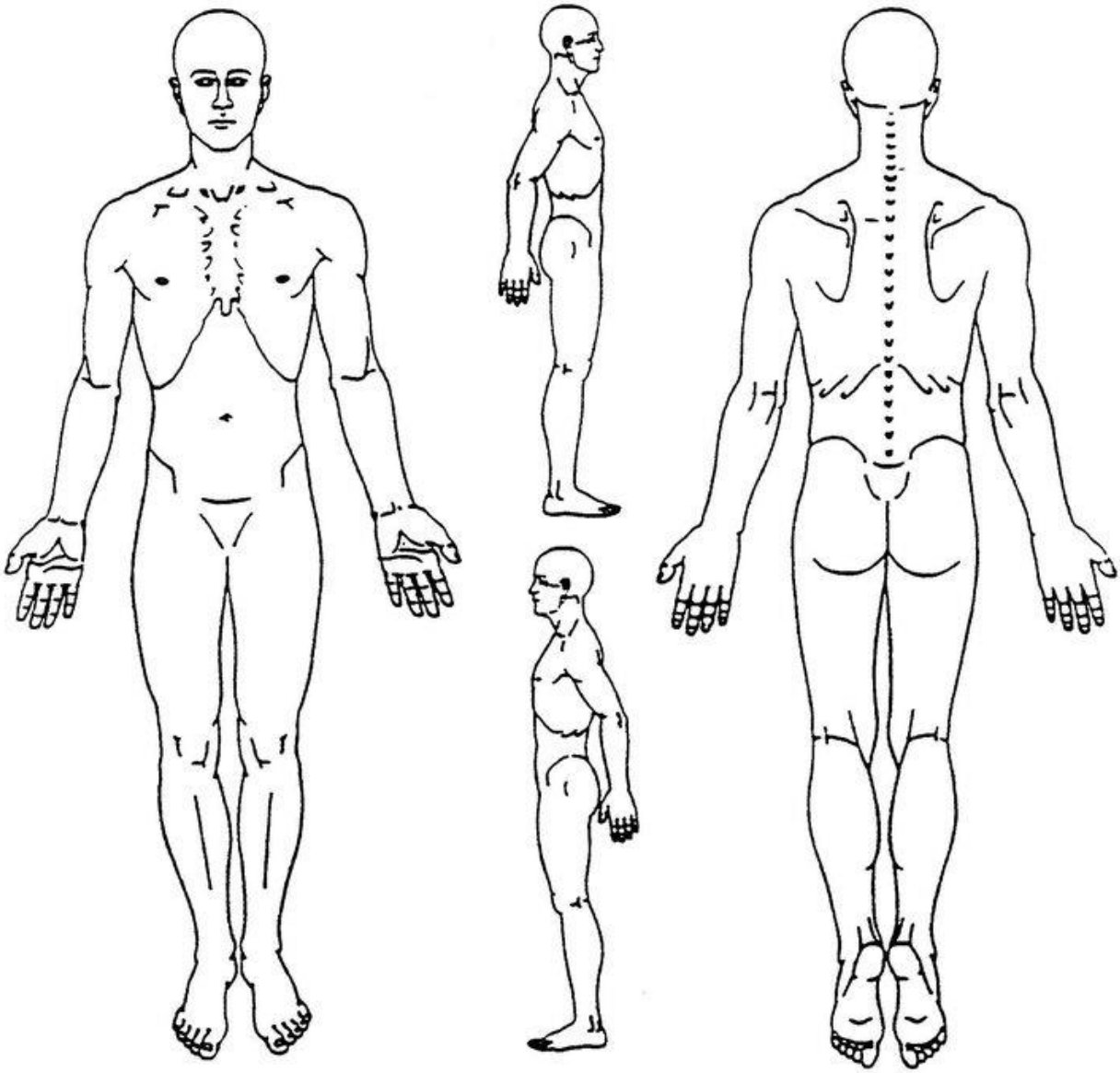
_____

_____

Body Image Diagram: Place the appropriate symbol on the body image diagram using the following symbols

X – Sharp Pain
/ - Muscle Tension/Tightness

▲ - Radiating Pain
↯ - Numbness/Tingling



Please Explain below if needed:

CONSENT TO TREAT

I, _____, hereby consent for Dr. James R. Guzman, PT, DPT, PRC and Advanced Integrative Concepts LLC to provide medical care and treatment to me, or the above-named patient's, considered necessary and proper in diagnosing or treating my/his/her physical condition including the following procedures:

- Physical Therapy Evaluation
- Manual Therapy
- Gait Assessment
- Foot Orthotic Impressions
- Corrective Exercise
- Neuromuscular Training

I understand that treatment outcomes may vary between patients and underlying circumstance and no guarantees can be made regarding the potential success of the procedure to provide the desired outcomes. Nevertheless, I understand that Dr. James R Guzman, PT, DPT and Advanced Integrative Concepts LLC are fully dedicated to doing everything they can to help me achieve an optimal outcome within the parameters of their scope of practice and office policies.

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the physical therapist at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of photographs or videos for diagnostic measures appropriate for a thorough evaluation.

Signature of patient or parent if minor:

_____ Date_____

Authorization to Use or Disclose Protected Health Information (PHI)

I understand that as part of my healthcare, Advanced Integrative Concepts LLC. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment.
- A means of communication among health care professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services were provided.
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I authorize James R. Guzman, PT, DPT to release any information including the diagnosis and the records of any treatment or exam rendered to me or my child during the period of care to my insurance company and/or health practitioners.

Signature of patient or parent if minor:

_____ Date_____

CONSENT TO PHOTOGRAPHY & VIDEO

I authorize Dr. James R. Guzman, PT, DPT d.b.a. Applied Integrative Concepts LLC the use of my records including any photographs and videos taken for teaching or educational study clubs/seminars and/or marketing purposes.

Signature_____ Date_____

AGREEMENT TO PAYMENT

I understand that James R. Guzman and Applied Integrative Concepts LLC is a cash-based entity and does not currently accept medical insurance. I agree to be ultimately responsible for payment of all services rendered on my behalf or my dependents. Additionally, payment is to be promptly paid upon services rendered. I hereby do authorize treatment and agree to pay all related professional fees.

FEE SCHEDULE:

2-Hour Initial Evaluation - $275.00

90-Minute Follow-up Visit - $175.00 - $200.00

Custom foot orthotics [if warranted] - $475.00

[We accept cash, personal check, and Zelle **credit card not currently accepted]

Signature_____ Date_____

Texas Board of Physical Therapy Examiners

1801 Congress Ave Ste 10.900 ***512/305-6900***
Austin, Texas 78701 ***ptot.texas.gov***

Physical Therapy Treatment without Referral Disclosure

Please read carefully and acknowledge below:

I understand that physical therapy treatment without a referral will be based on the physical therapist's examination and evaluation of my current condition which may result in identification of movement and mobility dysfunction.

I understand that the physical therapist will not diagnose an illness or disease, and that physical therapy is not a substitute for a medical diagnosis.

I understand that if a medical diagnosis has already been established by a qualified healthcare practitioner, the physical therapist will take it into consideration during the evaluation process.

I understand that the physical therapy plan of care developed by the physical therapist may not be based on radiological imaging.

I understand that if images have previously been obtained, the physical therapist may use the information as part of the evaluation process.

I understand that if the physical therapist identifies a need for radiological imaging, the physical therapist may recommend that radiological imaging be obtained.

I understand that my health insurance may not cover physical therapy services if provided without a referral from a qualified healthcare practitioner.

I acknowledge that I have received the above disclosure.

Patient Name (print): _____

_____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, Print Name and Relationship to Patient

Approved by the Texas Board of Physical Therapy Examiners – 10/11/2019