Hello,

Thank you for choosing Renaissance Physical Therapy. I look forward to the opportunity to help you live the life you want to live!

Renaissance Physical Therapy & Wellness started out of a burning desire to help spread a holistic, comprehensive, personalized, and multi-disciplinary approach that was not being offered in this area given the confines of the traditional healthcare system. My own personal wellness journey has blessed me with exposure to these methods, and it is my hope that I am able to bring you the same benefit that it has brought me.

Here is what you can expect from me:

1) With each session, we will holistically assess the state of your system which looks to identify the root cause of issues you may be having and we will provide you with some strategies to work on between sessions to help address your issues.
2) I am available to answer questions via phone/text/email between sessions.
3) I will be in frequent contact with any members of our multi-disciplinary network of providers who may also be involved in your care and will be on site to assist and ensure continuity of care if it is determined that you need to see one of the dental/vision providers in our network.

For your first session, please bring:

1) The shoes you typically wear throughout your day and/or when you exercise.
2) Any eye glasses/contacts you wear.
3) Any dental appliances you may have been issued at any point.

Thank you for choosing Renaissance Physical Therapy & Wellness. It is an honor to be involved in your care, and it is a responsibility that I don't take for granted. I look forward to working with you!

Be well,

Frank

Frank Mallon PT, DPT, PRC
Founder, Renaissance Physical Therapy & Wellness, LLC
267-402-0242
RenaissancePhysicalTherapy@gmail.com

Name: ____ Date of Birth: ___ /___ /____

Male ___ Female ___

Address: ______________________________________ City: ___________________________

State: ______________ Zip: ____________

Cell Phone #: _____________________________________

Home Phone #: ___________________________________

E-Mail Address: ___________________________________

Marital Status (check one):

Married: ______ Single: ______ Divorced: ______ Separated: ______ Other: ____________

Emergency Contact: ____________________ Relationship: ____________________________

Emergency Telephone: ____

Employer Name: ____

Occupation: ____

Referring Physician: ____

Date last seen by this physician: _____ /____ /_____

Primary Care Physician: ____

Physician's #: _______________________________

Patient/Client Questionnaire (This information is kept confidential)

Name: ____ Today's Date: _____ /____ /_____

From whom did you hear about us?

____

History of current condition (reason for visit, date of onset, etc.):

____

____

____

____

____

Any special tests that have been performed (i.e.: X-ray, MRI, CT Scan):

____

____

____

Have you had any other treatments for your current condition (i.e.: PT, Chiropractic, Massage, Acupuncture)?

____

____

____

Please list all current medications:

____

____

____

Please list any allergies:

____

____

Previous surgeries (please note year):

____

____

____

Do you now have, or have you had, any of these issues or conditions? (Check all that apply)

○ Change in bowel movements ○ Lasting/persistent joint pain ○ Irritable bowel ○ Blood in stools/urine ○ Hot flashes ○ Vertigo or dizziness ○ Ringing in ears ○ Persistent nose bleeds ○ Difficulty concentrating/ "Brain Fog" ○ Vision changes ○ Hepatitis ○ Tuberculosis ○ Diabetes ○ Recent dental work	○ Learning Disabilities ○ Tiredness/fatigue ○ Muscle spasms ○ Fainting spells ○ Eating disorder/difficulty ○ Difficulty sleeping ○ Head injuries (concussion/whiplash) ○ Knocked unconscious ○ Spinal injuries ○ Recurrent/persistent headaches ○ Meningitis ○ Stomach ulcers/colitis ○ Heartburn/indigestion ○ Shortness of breath ○ Stroke ○ Inflammatory arthritis (Rheumatoid, Ankylosing) ○ HIV/AIDS	○ Anemia ○ Bladder/kidney Issues ○ High blood pressure ○ Anxiety/depression ○ Allergies to latex or medication ○ Infectious disease ○ Difficulty breathing/lung problems/asthma/COPD ○ Osteoporosis ○ Heart condition ○ Abdominal surgery/ cesarean section ○ Blood clots ○ Circulation problems ○ Thyroid problems ○ Multiple Sclerosis ○ Cancer ○ Chemical dependency (i.e.: alcoholism) ○ Presently pregnant

Have you recently noted any of the following that are new, unusual, or atypical for you? (Check all that apply)

YES NO Weight loss/gain	YES NO Vision troubles	YES NO Persistent cough
YES NO Nausea/vomiting	YES NO Eye redness	YES NO Heartburn/indigestion
YES NO Dizziness/ lightheadedness	YES NO Skin rash	YES NO Blood in stool or urine
	YES NO Problems sleeping	YES NO Problems urinating
YES NO Fatigue/weakness	YES NO Hearing problems	YES NO Bowel changes
YES NO Fever/chills/sweats	YES NO Joint/muscle swelling	YES NO Tremors/seizures
YES NO Numbness/tingling	YES NO Easy bruising/bleeding	YES NO Abdominal surgery

Please explain any items circled above or list any other medical issues not recognized above:
____
____
____
____

Do you exercise regularly? YES NO

Have you been admitted to a hospital in the past year? YES NO

How many cups of caffeinated beverages (coffee, soda, tea) do you drink per day? ______

Do you or did you used to smoke? ____ If yes, how many packs per day? ___ If you quit, when? _____

Do you drink alcohol? ____ If yes, how many days per week do you drink? ___
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? ___

On a scale of 1-10, where would you rate your current daily stress level?
(0 = no stress, 10 = most possible)

0 1 2 3 4 5 6 7 8 9 10

Is there anything about your case or your personal preferences that would be helpful for us to know so that we can provide you with the most optimal experience?
____
____
____
____

Additional comments:
____
____
____
____

PAYMENT/BILLING POLICIES:

Renaissance Physical Therapy & Wellness, LLC is a fee-for-service clinic. This means that payment is due at the time services are rendered and we will not bill your insurance company. If further reports or documentation are requested, these will be provided. We accept cash, personal checks, credit card (a 3.7% processing fee may be added), and Venmo. We are available for at-home visits at additional costs. Please clarify prior to your first treatment if you have any questions regarding charges or fees.

X ____ **Date:** ___ /___ /____
Signature of patient/legal guardian

CANCELLATION/NO-SHOW POLICY

Renaissance Physical Therapy & Wellness, LLC reserves the right to charge the full session fee for no-shows or cancellations with less than 48-hour notice if the appointment slot cannot be filled. In the event of a late arrival, the session time will be adjusted to still end at the scheduled time and the full session fee will still be charged.

X ____ **Date:** ___ /___ /____
Signature of patient/legal guardian

PRIVACY POLICY:

I understand that Renaissance Physical Therapy & Wellness, LLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.
PATIENT PRIVACY NOTICE
HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification Section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager.
I authorize the provider of service to contact me via phone/voicemail, email, fax, cell phone (including texts) or any other means of contacting me for purposes of: appointment scheduling or changing, test results, billings, releasing of medical information related to my condition, mailers, advertising, etc.
I will assume responsibility to notify them whenever this information changes.

X ____ **Date:** ___ /___ /____
Signature of patient/legal guardian

CONSENT TO TREATMENT:

Renaissance Physical Therapy & Wellness, LLC is a physical therapy and integrative movement consultation service. I understand that my treatment may include (with my consent) integration and collaboration with providers from other disciplines, such as (but not exclusive to) physicians/osteopaths, dentists, optometrists, podiatrists, nutritionists, acupuncturists, chiropractors, and fitness professionals in order to help provide me with a complete, holistic, and integrated approach when necessary. Though highly specialized, I recognize that my treatment will consist of therapeutic exercise and neuromuscular reeducation techniques, as well as manual therapy techniques and treatment forms that are published or otherwise publicly known.

Non-manual techniques (exercise) may result in increased soreness which may last from 24-72 hours. Symptoms may also change and move to other parts of the body. This is not unusual and is rarely a concern, however, please ask if you have any concerns or questions. The number of treatments needed and recovery time can vary due to the age of injury, number of times injured, age of patient, and many other contributing factors. I understand that the delivery of these services is not an exact science and that no results can be guaranteed. I have read and fully understand the above statements. I understand the nature of the treatments at Renaissance Physical Therapy & Wellness, LLC and I recognize that it is my responsibility to express any concerns or questions I have to Renaissance Physical Therapy & Wellness, LLC.

I authorize Francis Mallon, PT, DPT, PRC and the fully trained staff to use treatment techniques as deemed necessary for my safe and effective recovery. I do hereby consent to such treatment by the authorized personnel of Renaissance Physical Therapy and Wellness, LLC as may be dictated by prudent medical practice by my illness, injury, or condition. This is intended as a waiver of liability for such treatment excepting acts of negligence.

I have read and completely understand the above written statements.

X ____ **Date:** ___ /___ /____

Signature of patient/legal guardian