



Patient Information

Today's Date: Referred by:

Primary reason for receiving therapy today? Body part to be treated?

First Name: MI Last Name:

Mailing Address:

City: State: Zip:

SSN: Gender: M F Marital Status S M D W
DOB: Age: Height Weight

Home phone: Work phone: Cell Phone:

E-mail address:

Emergency Contact Name and Phone Number:

Employed: Full time/ Part time/ Unemployed Student: Full time/Part time

Patient's Employer Occupation

Address: City: State: Zip:

Accident/Injury Information

Date of Accident or Injury related to this current episode:

How did accident or injury occur?

Accident Type: Work Auto Fall None Other (Please circle accident type)

If Auto, what state did the accident occur? Time of accident?

Are there any issues that might interrupt your ability to attend therapy?

Insurance Information

Primary Insurance Carrier

Address

Insurance Phone:

Policy number

Group number

Relationship to patient: Self Spouse Parent Other

Social Security #:

Policy Holder's Name

Address:

City: State: Zip:

Birth date: Sex: M or F

Home Phone:

Work Phone:

Employer:

Secondary Insurance Carrier

Address

Insurance Phone:

Policy number

Group number

Relationship to patient: Self Spouse Parent Other

Social Security #

Policy Holder's Name

Address:

City: State: Zip:

Birth date: Sex: M or F

Home Phone:

Work Phone:

Employer:

All current insurance information has been provided and I have documented all insurance companies to be filed on this page.

Patient/Guardian

Date



Medical History

Are you on a work restriction from your Doctor? Y N Ht: _____ Wt: _____
Do you smoke? Y N Do you have a pacemaker? Y N
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Y N
ALLERGIES: Please list any medical allergies: _____

Have you RECENTLY noted any of the following (Check all that apply)?

- | | | |
|---|--|--|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> constipation |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> fainting |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough |
| <input type="checkbox"/> changes in bowel/bladder function | <input type="checkbox"/> falls | <input type="checkbox"/> headaches |

Have you EVER been diagnosed with any of the following conditions (Check all that apply)?

- | | | |
|---|--|---|
| <input type="checkbox"/> cancer: _____ | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems: _____ | <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> lung problems: _____ | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> eye problems/infection | <input type="checkbox"/> other arthritic condition | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> stroke | <input type="checkbox"/> bladder/UTI | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problems/infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> bone/joint infection: _____ | <input type="checkbox"/> STD/HIV | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> chemical dependency(e.g. alcoholism) | <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> pneumonia |

Has anyone in your immediate family (parents, siblings, grandparents) EVER been diagnosed with any of the following conditions (Check all that apply)?

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> cancer: _____ | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> heart problems: _____ | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> stroke |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots |

Do you ever leak urine when you cough, laugh, sneeze, lift, bend over or exercise? **Yes No**
Do you ever leak urine with a strong urge or on the way to the bathroom (Can't make it in time)? **Yes No**
Do you ever leak stool, even in small amounts on the way to the bathroom? **Yes No**
Do you ever leak stool, even in small amounts when unaware? **Yes No**

During the past month, have you been feeling down, depressed or hopeless? **Yes No**
During the past month, have you been bothered by having little interest or pleasure in doing things? **Yes No**

Are there any other conditions that we should know about (list)? _____

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |

Please list any surgeries or other conditions for which you have been hospitalized, including dates if able:

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
|----------|----------|----------|

Therapist Initials: _____
Date: _____



What date did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: Getting Better Getting Worse Staying about the same

Treatment received so far for this problem (chiropractic, injections, etc) _____

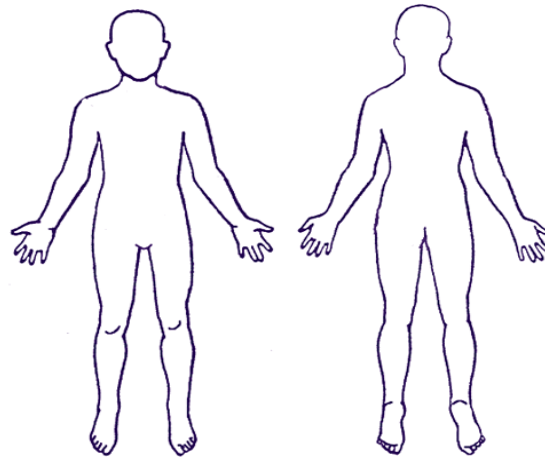
Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before No Yes When _____ Treatment rec'd _____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you
Feel symptoms on the chart to the right with
the following symbols to describe your symptoms:



- ↓ Shooting/sharp pain
- Dull/aching pain
- III Numbness
- = Tingling

My symptoms currently: Come and go Are Constant Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms the best? Morning Afternoon Evening Night After exercise

Using the 0 to 10 scale with 0 being “no pain” and 10 being the “worst pain imaginable” please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

Patient/Guardian Signature: _____ **Date:** _____



Consent for Care and Treatment, Benefit Assignment/Release of Information, Information Privacy

I, _____, do hereby agree and give my consent for Physical Therapy Today to furnish medical care and treatment to me that is considered necessary and proper in diagnosing or treatment my physical and mental condition. I hereby assign all medical to include major medical benefits to which I am entitled, including Medicare, Medicaid, and third party payers to Physical Therapy Today. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records to secure payment. Physical Therapy Today will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health Care operations generally include those activities we perform to improve our quality of care.

A summary of our Notice of Privacy Practices is furnished to you at the time of admit, however a complete version of our Privacy Practices is available upon request.

Sexual harassment

Sexual harassment is not tolerated in any form or fashion. Please refrain from any inappropriate gestures, comments, or jokes towards staff, visitors and or other patients.

Patient initials _____

Workers Compensation

If you are a worker’s compensation patient and you miss an appointment that is not made up in the same week, we are required to communicate the missed appointment to your insurance adjuster, case manager, physician/ or employer.

Patient initials _____

If you are related to physician, work for a physician, or part of a physician’s group, please initial and see front office immediately for additional paperwork.

Patient initials _____

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for that amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit the payment to Physical Therapy Today.

The above may not apply for those patients that are considered Worker’s Compensation. However, be advised if you claim worker’s compensation benefits and you are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. I understand what financial obligations I have, as benefits verified are done as a courtesy and is not guaranteed until claims are received at your insurance. I also understand that any charge(s) that is not covered by my insurance is my responsibility.

I have read, understand and agree to all the above

Patient/Guardian/Responsible Party Signature

Date

Witness

Date



PHYSICAL THERAPY
T • O • D • A • Y

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from Physical Therapy Today.

X _____ Date: _____

In lieu of patient signature, I, _____, a staff member of Physical Therapy Today, state that _____ has been given our current Notice of Privacy Practices.

X _____ Date: _____

Security Questions

What is your favorite color? _____

What City were you born in? _____

What is your mother's maiden name? _____

Dr's Appointment

My next doctor appointment is: _____