The Physical Therapy Effect

To ensure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your Physical Therapist or Front Desk Associate can assist you. Thank you for your time.

Name: _____ Sex:_____ Date of Birth: _____

Age: _____ Height: _____ Weight: _____ Nickname: _____

Mobile/Home Phone #:_____ Work #:_____

Address: _____

Email Address: _____ Referring MD: _____

How did you hear about us: (please circle) Internet Friend Walk-In Other:_____

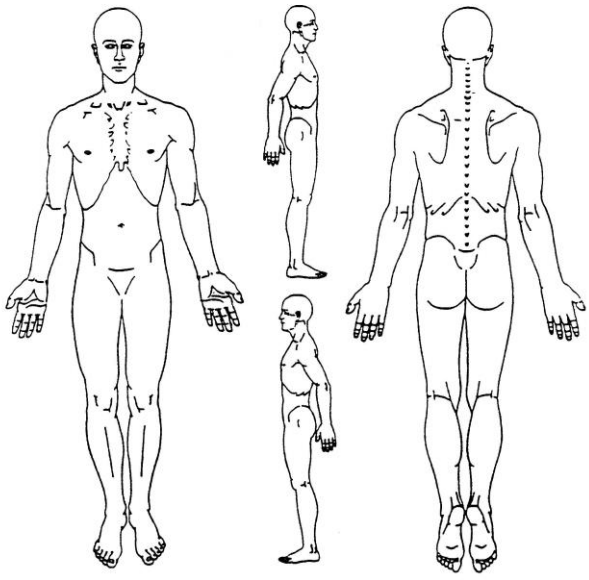
Tricare Patients Only please list Social Security Number: _____

Emergency Contact: _____Relationship: _____ Contact #: _____

1) What brings you here today? _____
2) Please give a brief description of your symptoms:_____

   _____

   Date of Onset:_____



Shade in region(s) of pain or abnormal sensation

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3) With regards to this injury or pain only, was surgery performed?

☐ Yes ☐ No

If so, Type: _____ Date of Surgery: _____

4) Was the onset/time of this episode:

☐ Gradual ☐ Sudden

Any previous episodes? Explain: _____

☐ Yes ☐ No

5) How did your injury occur?

☐ Unknown ☐ A fall ☐ Overuse
☐ While lifting ☐ Trauma ☐ Dental
☐ Car Accident ☐ At work ☐ Degenerative Process
☐ During Rec./Sports ☐ Other_____

6) Since the onset, are your symptoms getting:

☐ Better ☐ Worse ☐ Staying the Same

7) Nature of pain/symptoms: (mark all that apply)

☐ Sharp ☐ Periodic
☐ Aching ☐ Constant
☐ Dull ☐ Occasional
☐ Throbbing ☐ Other:_____

8) Rate your pain on scale of 0-10 below. Place 3 circles: (Best, Current, Worst)

Best - 0 1 2 3 4 5 6 7 8 9 10

Current - 0 1 2 3 4 5 6 7 8 9 10

Worst - 0 1 2 3 4 5 6 7 8 9 10

9) As the day progresses, do your symptoms:

☐ Increase ☐ Decrease ☐ Stay the Same

10) Does your pain wake you at night:

☐ Yes ☐ While lying down
☐ No ☐ Only with changing positions

11) What Position do you sleep? (mark all that apply)

☐ Back ☐ Chair/recliner ☐ Left side
☐ Stomach ☐ Right side

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12) Average amount of sleep per night? _____

13) Do you wake with stiffness in the morning?

☐ Yes ☐ No

14) Occupation:_____ Employer:_____

☐ Full Time ☐ Self Employed ☐ Retired
☐ Part Time ☐ Student ☐ Unemployed

15) Previous Functional Level: (mark all that apply)

☐ Independent in all activities
☐ Independent in all self-care
☐ Difficulty performing self-care activities
☐ Need assistance with self-care activities
☐ Difficulty performing household chores
☐ Need assistance with activities in community outside of home

16) Current Functional Level: What specific activities are you unable to do because of your symptoms?

_____

17) What positions, activities, and time of day aggravate your symptoms?

_____

18) What positions, activities, and time of day relieve your symptoms?

_____

19) Have you had previous treatment for this condition? (mark all that apply)

☐ Medication ☐ Physical Therapy ☐ Chiropractor
☐ Injection ☐ Traction ☐ Bracing/Taping
☐ Manipulation DC/DO ☐ Naturopathic Doctor ☐ Massage Therapy
☐ Exercise ☐ Acupuncture ☐ Oriental Medicine
☐ Other _____

20) Have you had any tests done relating to your condition? (mark all that apply)

☐ X-ray ☐ CT Scan ☐ Arthrogram
☐ MRI ☐ Bone Scan
☐ Lab Tests Results: _____

21) Are you currently taking any medications or supplements, either prescription or over the counter? Please List.

_____

_____

22) Do you have any allergies to food or medications?

_____

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23) How would you rate your general health?

☐ Excellent ☐ Average ☐ Fair ☐ Poor

24) Have you had any falls this year; if yes, how many times have you fallen this year?

☐ Yes, # of falls_____ ☐ No

25) Do you have a prior or current history of smoking?

☐ No ☐ Yes

26) How frequently do you exercise outside of normal daily activities?

☐ 5+ days/wk ☐ 1-2 days/wk
☐ 3-4 days/wk ☐ Occasionally
☐ Zero

What type(s) of exercise/sports? _____

27) What are your goals coming to Physical Therapy?

_____

28) Please indicate your activity level due to your present condition as compared to your previous level before injury.

☐ Inactive ☐ Normal

29) Past Surgical History:

☐ Types of Surgery and Surgical Dates: _____

☐ Types of Surgery and Surgical Dates: _____

30) Additional Comments you would like to add:

_____

_____

_____

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MEDICAL HISTORY

As you review the following list, please check any problems or conditions that you are currently experiencing or have experienced.

General Health

- ☐ Good General Health
- ☐ Recent weight change
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Chronic Fatigue Syndrome
- ☐ Fever/Chills
- ☐ Other:_____

Spine/Orthopedic/Bone

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Joint Pain
- ☐ Muscle Pain/Stiffness
- ☐ Difficulty Walking
- ☐ Fractures
- ☐ Dislocations
- ☐ Swelling
- ☐ Other:_____

Ears, Eyes, Nose, Mouth, Throat

- ☐ Change in Taste/Smell
- ☐ Change in swallow/chewing
- ☐ Ringing in Ears
- ☐ Sinus Infection
- ☐ Recent dental work
- ☐ Change in Vision
- ☐ Other:_____

Gastrointestinal

- ☐ Constipation/Diarrhea
- ☐ Nausea/Vomiting
- ☐ Painful Bowel Movements
- ☐ Stomach/Abdominal Pain
- ☐ Ulcer
- ☐ Crohns
- ☐ Bowel Incontinence
- ☐ Other:_____

Rheumatologic

- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Auto-Immune Disorders
- ☐ Psoriatic Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Other:_____

Urinary

- ☐ Kidney Stones/Infection
- ☐ Frequent UTI/Bladder Infections
- ☐ Urinary Incontinence/Urgency
- ☐ Urinary Retention
- ☐ Painful Urination
- ☐ Other:_____

Reproduction

- ☐ Testicular Pain
- ☐ Prostate Disease
- ☐ Sexual Difficulty
- ☐ Irregular Periods
- ☐ # Pregnancies:_____
- ☐ If Pregnant # of weeks:_____
- ☐ Currently Breastfeeding
- ☐ STD
- ☐ Endometriosis
- ☐ Oral Birth Control Pills
- ☐ Ovarian Cysts
- ☐ PCOS
- ☐ Pelvic Pain
- ☐ Other:_____

Blood

- ☐ Deep Vein Thrombosis
- ☐ Arteriosclerosis
- ☐ Artery Bypass Surgery
- ☐ HIV/AIDS
- ☐ Cancers
- ☐ Other:_____

Cardiac

- ☐ History of Heart Attack
- ☐ Angina
- ☐ Implantable Defibrillator
- ☐ Pacemaker
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Bypass surgery
- ☐ Other:_____

Neurologic

- ☐ Seizure
- ☐ Concussion
- ☐ Traumatic Brain Injury
- ☐ Stroke
- ☐ Disc Bulge/Herniation
- ☐ Dizziness/Vertigo
- ☐ Memory Loss
- ☐ Migraine Headaches
- ☐ Balance Difficulties
- ☐ Other:_____

Skin

- ☐ Cellulitis
- ☐ Psoriasis
- ☐ Hives
- ☐ Rash/Itching
- ☐ Other:_____

Psychiatric

- ☐ Severe Depression
- ☐ Panic Attack
- ☐ Psychotic Disorder
- ☐ Borderline Disorder
- ☐ Suicide Attempt
- ☐ Other:_____

Cancer

- ☐ History of Cancer - Type:_____ Treatment:_____
- ☐ Blood Disorder
- ☐ Other:_____

The Physical Therapy Effect

Office Payment Policy

Please initial your payment method and sign below that you have read, understand, and agree with all the information on this page:

_____ 1. PRIVATE HEALTH INSURANCE (PPO): Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility of a deductible (amount paid by the patient before the insurance policy begins payment for services) and either a copay (a set dollar amount per visit) or coinsurance (a percent of the allowed charges). Deductibles and copays are due at the time of service. We will bill you for your coinsurance or other remaining payments due after we have been paid by your insurance or notified of their denial for payment.

_____ 2. VA: Authorization from your insurance must be obtained prior to treatment. Any copay or coinsurance is due at the time of treatment.

_____ 3. MEDICARE: The Physical Therapy Effect, P.C. is a certified participating Medicare provider. Medicare has an annual deductible of $186.00 and an annual benefit limit of $2040.00 for PT and Speech combined. Secondary insurance plans may cover the patient portion due until your Medicare benefits are exhausted. Please verify all your insurance benefits and be sure you understand your insurance coverage.

_____ 4. Cash, Check or Card: Payment will be due at time of service unless an agreed upon monthly payment plan has been agree upon with The Physical Therapy Effect.

_____ 5. WORKER'S COMPENSATION/ AUTO CLAIMS: Authorization from your insurance adjuster is required before you can begin treatment. Please provide the office manager with the name and phone number of your adjuster, the date of your injury and your claim number, and any other pertinent information.
Adjuster Name: _____ Claim Number: _____
Financial Provider Name: _____ Date of Incident: _____

ATTENTION AUTO ACCIDENT VICTIMS AND WORKER'S COMPENSATION INJURY PATIENTS:
Please sign a release of information authorizing us to discuss your treatment with your attorney

I have reviewed this office policies statement and initialed next to my payment method. I have discussed it with the clinical office manager and all my questions have been answered to my satisfaction and I understand all the information that has been explained to me.

Signature: _____ Date: _____
CMM Rev. 4/2006
(Failure to sign this form absolves The Physical Therapy Effect, P.C. of responsibility of billing patient's insurance, if pertinent.)

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CONDITIONS OF REGISTRATION

Patient Name: _____ DOB: _____

1. Release of Information: I authorize **The Physical Therapy Effect (TPTE)** to release my medical records to my health insurance for the purpose of billing and processing of my claim. I also agree to allow The Physical Therapy Effect to release my medical records and discuss health related and financially related issues to all health care providers, case managers, insurance representatives and lawyers that are involved in my case. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

2. Assignment of Insurance Benefits / Financial Responsibility: The Physical Therapy Effect has my permission to submit billings to my insurance company on my behalf and I authorize these payments to be made directly to The Physical Therapy Effect. I agree to pay all outstanding balances on my account within 60 days of receiving a balance due statement. Should my account be referred to an attorney, I will pay actual attorney fees. **I acknowledge that verification of insurance benefits is provided as a courtesy and NOT a guarantee of payment.**

3. Notice of Privacy Practices: I acknowledge that I have been offered a copy of The Physical Therapy Effect's notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by TPTE and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

4.Cancellation, No Show and or Missed Appointments: A total of 3 consecutive absent appointments will result in the removal of all pre scheduled future appointments, it also allows TPTE to call my primary care doctor and or my financial provider and inform them of my absences which may lead to denial of coverage of future appointments by my financial provider.

5. Consent for Care and Treatment: I, the undersigned, hereby and give my consent for The Physical Therapy Effect, P.C. to furnish medical care and treatment as considered necessary and proper in diagnosing or treating his/her physical condition.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to The Physical Therapy Effect, and I understand that I am financially responsible for any remaining balance owed to The Physical Therapy Effect. I certify that I have read, understand, and agree to all the conditions of registration, and request and consent to the above-named patient to receive appropriate services from The Physical Therapy Effect.

Patient / Guarantor Signature: _____ Date: _____

Print Patient / Guarantor Name: _____Relationship: _____