PATIENT INFORMATION

PATIENT (LEGAL) NAME:______________________________ SEX:________ BIRTHDATE:______________

PREVIOUS/MAIDEN NAME(s): ______________________________ SSN:______________ PHONE:______________

PHYSICAL ADDRESS:____

City State Zip

MAILING ADDRESS:____ CELL:______________

EMPLOYER:____ PHONE:______________

SPOUSE NAME:______________________________ SPOUSE DOB:______________ PHONE:______________

SPOUSE EMPLOYER:______________________________ SPOUSE WORK PHONE:______________

EMERGENCY CONTACT (OUTSIDE OF HOME):______________________________ PHONE:______________

EMAIL (FOR APPT REMINDERS):____

HOW DID YOU HEAR ABOUT US?____

COMPLETE THIS SECTION IF PATIENT IS UNDER THE AGE OF 18 OR A COVERED DEPENDENT

(**Please note**: *If you are over 18, but covered by your parent(s) insurance plan, we can bill your parent(s) for you as a courtesy. Please understand you are ultimately responsible for any unpaid balances on your account.)*

MOTHER'S INFORMATION:

NAME: ______________________________ DOB:______________ PHONE:______________

ADDRESS:______________________________ EMPLOYER:______________ WORK PHONE:______________

FATHER'S INFORMATION:

NAME: ______________________________ DOB:______________ PHONE:______________

ADDRESS:______________________________ EMPLOYER:______________ WORK PHONE:______________

INSURANCE INFORMATION

PRIMARY:

POLICYHOLDER NAME:______________________________ DOB:______________ RELATION:______________

INSURANCE COMPANY:______________________________ ID/CLAIM #:______________GROUP #:__________

SECONDARY:

POLICYHOLDER NAME:______________________________ DOB:______________ RELATION:______________

INSURANCE COMPANY:______________________________ ID/CLAIM #:______________GROUP #:__________

PLEASE READ -- IMPORTANT INFORMATION

1. I consent to examination, treatment and procedures that may be performed during office visits considered necessary by the physical therapist.
2. I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.
3. I understand that I am financially responsible for all charges whether or not paid by my insurance.
4. I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs, will be added to the balance of my account.
5. I agree to make monthly payments on unpaid balances exceeding sixty (60) days even when insurance claims are pending. These payments will be established in accordance with APRS policy.
6. A one percent (1%) finance charge may be assessed against the unpaid balance of any and all accounts that I am responsible for in accordance with APRS policy.
7. If APRS bills my insurance company directly I will pay my co-payment of 20% per visit or the co-payment amount that coincides with my insurance policy. The co-payment is payable on a per visit or weekly basis.
8. Per HIPAA regulations, I acknowledge that this office has a posted Notice of Privacy Practice available in the patient reception area. A copy is available by request. We will not use or disclose your health information without your authorization, except as described in this notice.

____ ______________________

SIGNATURE OF RESPONSIBLE PARTY (PATIENT OR PARENT/GUARANTOR IF PATIENT IS A MINOR) DATE

MEDICAL INFORMATION

NAME: ____ DATE: _____________________________

A. PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS:

1. ARE YOU CURRENTLY ENGAGING IN ANY FORM OF EXERCISE? _____________

IF YES, LIST ACTIVITY, FREQUENCY AND INTENSITY: ____

2. HOW ACTIVE IS YOUR LIFESTYLE? _____ SEDENTARY ____ MODERATE PHYSICAL ACTIVITY _____ HEAVY PHYSICAL ACTIVITY

3. WHAT IS YOUR JOB TITLE IF CURRENTLY WORKING?____

DESCRIBE THE TYPES OF ACTIVITIES INVOLVED IN YOUR JOB (HEAVY LIFTING, STAIR CLIMBING, WALKING, SITTING AT DESK, ETC):

____

____

4. PLEASE INDICATE YOUR EXPECTATIONS AND GOALS FOR YOUR TREATMENT:____

____

B. **PLEASE FILL OUT YOUR PAIN LEVELS AND MARK WHERE YOU ARE FEELING THE PAIN ON THE DIAGRAM BELOW.**

PAIN / DISCOMFORT/DIZZINESS DESCRIPTION

SYMPTON FREQUENCY:

_____ CONSTANT
_____ COMES AND GOES AT REGULAR TIMES
_____ HAPPENS ONCE IN A WHILE

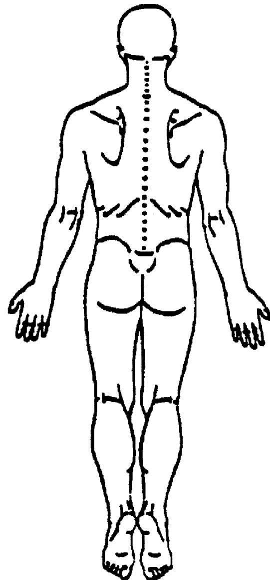
RELATIONSHIP OF SYMPTOMS TO SLEEP:

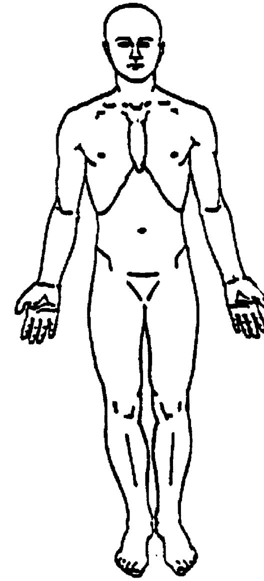
_____ WAKES FROM SLEEP
_____ PREVENTS SLEEP
_____ BETTER AFTER SLEEP

SYMPTOM SCALE- 0 BEING NONE AT ALL 10 BEING AS BAD AS IT CAN BE

AT WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENT	0	1	2	3	4	5	6	7	8	9	10
AT BEST	0	1	2	3	4	5	6	7	8	9	10

Key: /// Stabbing XXX Burning 000 Pins & Needles === Numbness





PATIENT SIGNATURE: ____ DATE:________________________________

MEDICATION INFORMATION

NAME:_______________________________ **DATE**:__________________

MEDICAL HISTORY:

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

_____ ALZHEIMER'S
_____ CARDIOVASCULAR DISEASE
_____ CURRENT INFECTION
_____ CVA/STROKE
_____ DIABETES TYPE 1/TYPE 2 (CIRCLE)
_____ FIBROMYALGIA
_____ HIGH BLOOD PRESSURE
_____ HISTORY OF CANCER
_____ HUNTINGTON'S
_____ LUPUS
_____ MUSCULAR DYSTROPHY
_____ HIV, HEPATITIS B, HEPATITIS C
_____ OSTEOARTHRITIS
_____ PARKINSON'S
_____ PREGNANT/POSSIBLY PREGNANT
_____ RHEUMATOID ARTHRITIS
_____ TRAUMATIC BRAIN INJURY
_____ PREVIOUS FRACTURED BONES (IF SO WHICH ONES):_______________________________________

OTHER:____

PLEASE LIST BELOW YOUR CURRENT PRESCRIPTION(S), OVER-THE-COUNTER, HERBAL, VITAMIN/ MINERALS / DIETARY (NUTRITIONAL SUPPLEMENTS) MEDICATIONS. IF YOU HAVE A CURRENT LIST OF YOUR MEDICATIONS WITH ALL OF THE BELOW INFORMATION, PLEASE PROVIDE IT TO THE FRONT OFFICE AND THEY CAN MAKE A COPY.

PRESCRIPTION MEDICATIONS:

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

OVER-THE-COUNTER / HERBAL/ VITAMIN /MINERAL / DIETARY (NUTRITIONAL SUPPLEMENT):

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

For Future Appointments Only

I ___________________________, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:_______________________________________ **DATE:**__________________

I ___________________________, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:_______________________________________ **DATE:**__________________

I ___________________________, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:_______________________________________**DATE:**__________________

MEDICARE REQUIRED QUESTIONS

Name:___________________________ Date:_______ Height:_______ Weight:______

At the present time, would you say that your health is (please circle one):

Excellent Very Good Fair Poor

Do you live alone? (Please circle one)

Yes No

If no, with whom do you live?____

When you are discharged from physical therapy, will your current residence change? (Please circle one)

Yes No

If yes, what will your new residence be?____

Do you have, or do you expect that you will need, any type of medical equipment due to your current condition? (For example: walking aid, etc.) (Please circle one)

Yes No

If yes, please list:____

Have you been in the hospital for this condition in the past 30 days? (Please circle one)

Yes No

Have you been in the nursing home/skilled nursing facility for this condition in the past 30 days? (Please circle one)

Yes No

Are you currently seeing any other healthcare providers for this condition? (Please circle any and all that apply)

Medical Doctor
Nurse Practitioner
Chiropractor
Physical Therapist
Occupational Therapist
Other:____

Have you been treated for this condition at this physical therapy facility or a different physical therapy facility in the past? (Please circle one)

Yes No

Since the beginning of this year, have you received treatment for this or a different condition by an occupational, speech, or physical therapist? (Please circle one)

Yes No

Falls:

- Have you fallen in the past year? (Please circle one) Yes No
- How many times?____
- What were the circumstances that made you fall?________________________________
  ____
- Did you have an injury from the fall?____
  ____