PATIENT INFORMATION

PLEASE COMPLETE ALL INFORMATION, SIGN AND HAVE YOUR INSURANCE CARDS AND DRIVERS LICENSE AVAILABLE FOR COPYING

Last Name:		First Name:		MI:	Daytime Phone:
Date of Birth:	Age:	Sex: MALE FEMALE	Marital Status: **S M W D**	Email Address:	
Mailing Address:			City:	State:	Zip:
Physical address(if different than above):			City:	State:	Zip:
Patient's employer:			Occupation:		
Employer address:			City:	State:	Zip:
Home phone:		Cell phone:		Work phone:	
Social security #:		Drivers License #:		Area of Pain:	
Type of injury/surgery WORK AUTO OTHER				Date of injury/surgery:	
Reason for visit:		Referring Physician:		How did you hear about us?	
How active is the patient? Any sports / Gym					
Has patient had physical this year? YES NO		Home therapy? YES NO			
Emergency contact:		Relationship:		Phone number:	

SPOUSE/PARENT/GUARDIAN - INFORMATION

Last Name:		First Name:		MI:	Home phone:
Date of Birth:	Age:	Sex: MALE FEMALE	Marital Status: **S M W D**	Relationship:	
Address:			City:	State:	Zip:
Employer:			Occupation:		
Employer address:			City:	State:	Zip:
Home phone:		Cell phone:		Work phone:	
Social security #:		Drivers License #:			

I, _____, hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to Physical Rx Physical Therapy. I understand that I am financially responsible for all charges whether or not they are paid by said insurance. I hereby authorize Physical Rx Physical Therapy to release all information necessary to secure the payment of said benefits. I understand that this assignment of benefits is irrevocable unless advised by me in advance. If any portiion of therapy is denied, I give Physical Rx Physical Therapy permission to act as my representative in appealing.

Consent for treatment: I hereby consent to receive treatment from the Outpatient clinic consistent with a plan of care authorized by my physican.

Signature **Date**

MEDICAL HISTORY AND PHYSICAL CONDITION INFORMATION

NAME: _____

CHIEF COMPLAINT/AREA OF PAIN:_____

Have you had treatment for this problem before? Yes No
If yes, where? _____ When? _____

Have you had surgery related to this problem? Yes No
If yes, where_____

List any medication you are currently taking:_____
_____

DOMINANT HAND: Right Left

DO YOU HAVE ANY METAL IMPLANTS? Yes No
DO YOU HAVE A PACE MAKER/DEFIBRILLATOR? Yes No
DO YOU HAVE ANY COMMUNICABLE DISEASES? Yes No

Do you now have or have you in the past had any of any of the following?

Allergies	Yes	No	Rheumatoid Arthritis	Yes	No
Arthritis	Yes	No	Osteoporosis	Yes	No
Balance Problems	Yes	No	Steroid Use	Yes	No
Cancer	Yes	No	Difficulty Controlling Bowel or		
Circulatory Problems	Yes	No	Bladder	Yes	No
Diabetes	Yes	No	Smoker	Yes	No
Dizzy spells	Yes	No	Alcohol consumption- None		
Headaches	Yes	No	Daily – Weekly - Monthly		
Hearing Problems	Yes	No	Any other Condition/Problem in which		
Heart Attack Disease	Yes	No	you are under the care of a Doctor		
Hernia	Yes	No	For_____		
High Blood Pressure	Yes	No	_____		
HIV/AIDS	Yes	No	_____		
Kidney Problems	Yes	No	_____		
Nervous Disorder	Yes	No	Other_____		
Pregnancy	Yes	No	_____		
Seizures	Yes	No	_____		
Sensitive to Heat/Ice	Yes	No	_____		
Vision Problems	Yes	No	_____		

If yes on any of the above, please explain and give approximate dates:
_____

Do you need assistance with the following:

Transportation	Yes	No	Meals	Yes	No
Shopping/Errands	Yes	No	Personal Care	Yes	No
Domestic Chores	Yes	No	Other _____		

Has your illness/disability caused any of the following:

Financial Problems	Yes	No	Family Problems	Yes	No
Emotional Problems	Yes	No	Other_____		

The above information is correct and to the best of knowledge

SIGNATURE: _____ DATE: _____

SUBJECTIVE INFORMAT N
PHYSICAL/OCCUPATIONAL THERAPY
INITIAL EVALUATION

NAME: _____
Medical Record _____
Date of Birth: _____
Occupation: _____

Today's Date: _____

1. Date of Injury: _____ Surgery Date (if any): _____ Referring Physician: _____

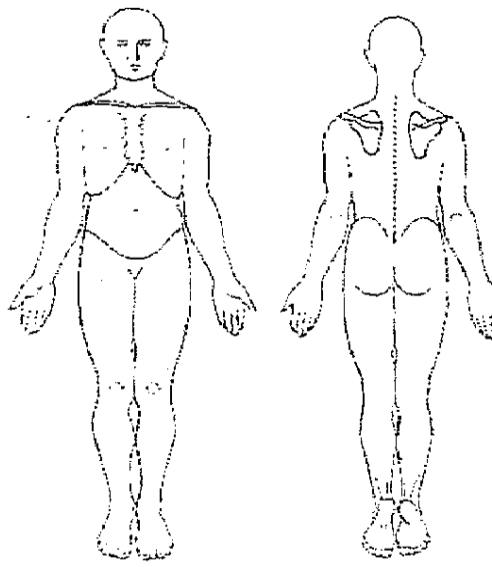
2. Describe your chief complaint (Why are you here today?) _____

_____

AND *where* it is located: Using the body chart below, describe the location(s) and type(s) of symptoms you are currently experiencing by drawing on the chart using the following:

Pain ////// Numbness ***** Tingling ::::::: Burning /\/\/\/\ Weakness ##### Other OOOOO

3. Have you had this condition before? ☐ Yes ☐ No
If YES, how long did it take to get better? ___ weeks/months/years
What helped you get better? _____



4. Have you received any treatment for this injury? ☐ Yes ☐ No

5. How did your injury occur? _____

_____

6. What types of duties/activities do you perform on your job daily?
☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Bending
☐ Reaching overhead/forward ☐ Twisting ☐ Kneeling ☐ Other

7. What makes your symptom(s) worse, and how long before your symptoms get worse? (Please indicate time by each item marked).
☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Bending
☐ Reaching overhead/forward ☐ Twisting ☐ Kneeling ☐ Other_____

8. What makes your symptom(s) better?
☐ Lying down ☐ Standing ☐ Rest ☐ Cold pack ☐ Medications
☐ Sitting ☐ Heat ☐ Exercises ☐ Stretching ☐ Other _____

9. Have you had any recent diagnostic tests (such as MRI, X-Ray etc)? ☐ Yes ☐ No
When: _____
Results: _____

10. Have you ever been in a car accident? ☐ Yes ☐ No 11. Medications: _____

12. Relevant Medical History:
☐ Diabetes ☐ Heart Problems ☐ Cancer ☐ High blood pressure ☐ Stroke ☐ Other _____

13. What does your injury limit you from doing? _____

14. What do you hope to achieve with physical therapy? _____

PATIENT'S SIGNATURE: _____ THERAPIST'S SIGNATURE: _____

/actf:vdc/td/dm/tc 10-01

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Physical RX - Physical Therapy, Inc.

I hereby acknowledge that I received a copy of **Physical RX - Physical Therapy, Inc**. Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I understand I may request the restrictions listed on the bottom of this acknowledgment

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

Requested Restrictions:

_____
_____
_____
_____
_____
_____

Restrictions received by **Physical RX - Physical Therapy, Inc.**
and were approved ☐ not approved ☐

by: _____, Privacy Officer on this date: _____

Cancellation & No-Show Policy

We take treatment cancellations seriously at Physical Rx because it can make the difference between whether you succeed or fail in your treatment plan. Your referring doctor has most likely prescribed a set frequency of treatment. This is his plan for you to re-gain function. Showing up as scheduled for these visits is your most important job. Working together we can help you achieve your goals in treatment.

We require 24-hours notice in the event of a cancellation.
It is your responsibility, when you call in; to have an alternative time in mind to insure that you will receive your full prescribed number of treatments that week. Cancellations may make it necessary for you to receive a treatment by one of our therapists, other than the one you originally scheduled with.

There is a $20 charge for cancellation without proper notice (24 hours). This charge will not be covered by insurance, but will have to be paid by you personally.

Please understand that your pain will probably vary during your course of treatment. Some conditions can seem to be a reason not to come in: whether you're feeling better or worse. It is important to come in and work with the Therapist to re-assess and treat you; and possibly progress your program.

When a patient doesn't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or physical therapist; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if there had been proper notice.

Please cooperate with us in this regard and we will do our best to have you back to full function quickly. We're looking forward to working with you.

I have read and fully understand the "Cancellation Policy"

Signature	Print Name	Date