

I. Personal Information

Name (Last, First) _____
 Birthdate _____ Gender: Male Female Marital Status: Single Married Other
 Address _____ Apt # _____ City _____ State _____ Zip _____
 Phone Number _____ Cell _____ Email: _____
 Emergency Contact _____ Relationship _____
 Home Phone _____ Work Phone _____ Extension _____
 Referred By _____

II. Insurance and Payment

Insurance Company _____ Insurance ID Number _____ Policy Holder _____
 Fee \$ _____ / per visit Insurance will cover _____ % Patient responsibility _____
 Deductible per year \$ _____ \$ _____ has been met Out of pocket \$ _____ \$ _____ has been met

III. Practice Policy & Patient Signature

Cancellations: Your appointment time is exclusively for you. It is for this reason that we request you give us a **minimum** of **24 hours notice** when canceling or you will be charged for the appointment. **The cancellation fee is \$50.00.**

Confidentiality: NOTICE OF PRIVACY AND PRACTICES As required by the Privacy Regulations of the Health Insurance Portability and Accountability Act (HIPAA) EFFECTIVE DATE: APRIL 14, 2003
 This office adheres to all rules regarding the confidentiality of patient records. Employees have access only to patient information necessary to properly perform the function of their jobs. This office will communicate with the patient's insurance companies and other health care practitioner(s) by letter, phone, or fax upon written permission from the patient. Only information necessary to process claims is released to insurance companies.

Patient Acknowledgement and Consent:

1. I have been informed of the regulations regarding the Patient Health Information Notice of Privacy and Practices by First Health Physical Therapy.
2. I further authorize First Health Physical Therapy to release to the appropriate agencies, any information acquired in the course of my, or the above named patient's, examination and treatment.
3. If assignment is accepted, I authorize and request my insurance companies to pay directly to First Health Physical Therapy benefits otherwise payable to me. **I understand that accepting assignment is a courtesy extended to me by this office and that I am financially responsible for any coinsurance, deductibles, and services that are not covered or deemed "not medically necessary" by my insurance companies.** Further, I understand that if an insurance claims **if not paid within 45 days, I am responsible for the full amount immediately.**
4. If assignment is not accepted, I understand that I am financially responsible for all services and payment is due at each visit unless other arrangements have been made.
5. If First Health Physical Therapy is a participating provider with my insurance companies, I understand that I am subject to the terms and conditions of my insurance policy.
6. I have read and understand the cancellation policy.
7. I authorize the release of any medical information necessary to process all claims, and I authorize First Health Physical Therapy to communicate with my insurance companies and other health care practitioner(s) as necessary by letter, phone, or fax.
8. I hereby authorize First Health Physical Therapy through its appropriate personnel to perform, or have performed upon me, or the above named patient appropriate assessment and treatment procedures relating to the diagnosis stated by my referring physician.
9. I have read the above information regarding my insurance policy. I certify that the information above, to the best of my knowledge, is true and accurate. I authorize my insurance carrier to pay First Health Physical Therapy directly for services provided. I agree to pay First Health Physical Therapy the entire amount of bills incurred for physical therapy services provided not covered by my insurance carrier.

Signature _____ Date _____

FIRST HEALTH PHYSICAL THERAPY

Medical History Form

1. Please mark the appropriate boxes that apply to your medical history:

- | | | | | |
|---|---|-------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Depression | <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Rheumatoid Arthritis | | | |

2. Please list any other diseases or conditions not mentioned:

3. Please list any previous surgeries:

4. Please list any medications you are currently taking and specify dosage:

5. What is your goal for therapy?

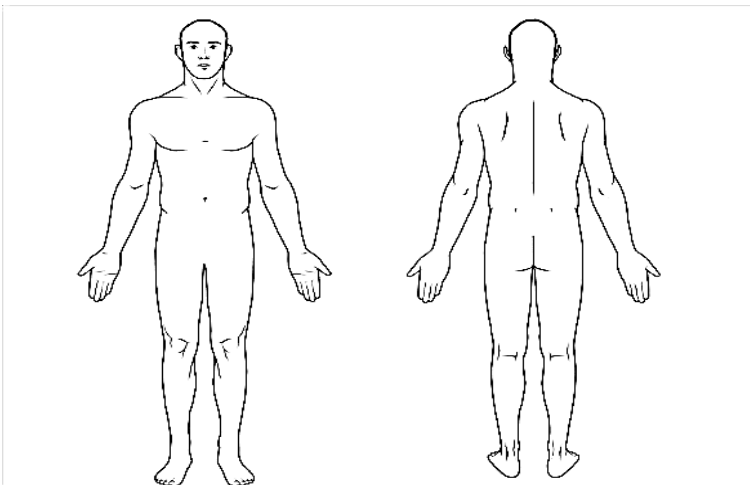
6. Please rate your pain at best: (0 = None) 0 1 2 3 4 5 6 7 8 9 10 (10 = Unbearable)

7. Please rate your pain at worst: (0 = None) 0 1 2 3 4 5 6 7 8 9 10 (10 = Unbearable)

8. Please circle the items that best describe your pain:

Sharp Shooting Radiating Twinge Dull/Ache Throbbing Numbness Tingling Burning

9. Please mark on the diagram where your pain is located:



10. Height ____ ft ____ in

11. Weight ____ lbs

12. Blood pressure: _____ systolic

_____ diastolic

SIGNATURE: _____

PATIENT NAME: _____ DATE: _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT

1. Pain Intensity

- (0) I can tolerate the pain I have without having to use pain medication.
- (1) The pain is bad, but I can manage without having to take pain medication.
- (2) Pain medication provides me with complete relief from pain.
- (3) Pain medication provides me with moderate relief from pain.
- (4) Pain medication provides me with little relief from pain.
- (5) Pain medication has no effect on my pain.

2. Personal Care (washing, dressing, etc.)

- (0) I can take care of myself normally without causing increased pain.
- (1) I can take care of myself normally, but it increases my pain.
- (2) It is painful to take care of myself, and I am slow and careful.
- (3) I need help, but I am able to manage most of my personal care.
- (4) I need help every day in most aspects of my care.
- (5) I do not get dressed, wash with difficulty, and stay in bed.

3. Lifting

- (0) I can lift heavy weights without increased pain.
- (1) I can lift heavy weights, but it causes increased pain.
- (2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
- (3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- (4) I can lift only very light weights.
- (5) I cannot lift or carry anything at all.

4. Walking

- (1) Pain does not prevent me from walking any distance.
- (2) Pain prevents me from walking more than 1 mile.
- (2) Pain prevents me from walking more than 1/2 mile.
- (3) Pain prevents me from walking more than 1/4 mile.
- (4) I can only walk with crutches or a cane.
- (5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting

- (0) I can sit in any chair as long as I like.
- (1) I can only sit in my favorite chair as long as I like.
- (2) Pain prevents me from sitting more than 1 hour.
- (3) Pain prevents me from sitting more than 1/2 hour.
- (4) Pain prevents me from sitting more than 10 minutes.
- (5) Pain prevents me from sitting at all.

6. Standing

- (0) I can stand as long as I want without increased pain.
- (1) I can stand as long as I want but, it increases my pain.
- (2) Pain prevents me from standing more than 1 hour.
- (3) Pain prevents me from standing more than 1/2 hour.
- (4) Pain prevents me from standing more than 10 minutes.
- (5) Pain prevents me from standing at all.

7. Sleeping

- (0) Pain does not prevent me from sleeping well.
- (1) I can sleep well only by using pain medication.
- (2) Even when I take pain medication, I sleep less than 6 hours.
- (3) Even when I take pain medication, I sleep less than 4 hours.
- (4) Even when I take pain medication, I sleep less than 2 hour
- (5) Pain prevents me from sleeping at all.

8. Social Life

- (0) My social life is normal and does not increase my pain.
- (1) My social life is normal, but it increases my level of pain.
- (2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
- (3) Pain prevents me from going out very often.
- (4) Pain has restricted my social life to my home.
- (5) I have hardly any social life because of my pain.

9. Traveling

- (0) I can travel anywhere without increased pain.
- (1) I can travel anywhere, but it increases my pain.
- (2) My pain restricts my travel over 2 hours.
- (3) My pain restricts my travel over 1 hour.
- (4) My pain restricts my travel to short necessary journeys under 1/2 hour.
- (5) My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment / Homemaking

- (0) My normal homemaking/job activities do not cause pain.
- (1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- (2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
- (3) Pain prevents me from doing anything but light duties.
- (4) Pain prevents me from doing even light duties.
- (5) Pain prevents me from performing any job or homemaking chores.

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Therapist Use Only		
Comorbidities:	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Multiple Treatment Areas	<input type="checkbox"/> Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) <input type="checkbox"/> Obesity <input type="checkbox"/> Surgery for this Problem <input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
		ICD9 Code: _____