Patient Information

Patient Name	**Employer**
Address	**Business Phone**
City/State/Zip	**Occupation**
Phone #	**Marital Status M S D W**
Birth Date	**SS #**
E-Mail	**Driver's License #**
Emergency Contact/ Relationship	
Phone#	

If Policy Holder is different then above please fill the appropriate fields.

Primary Insurance	Secondary Insurance
Policy Holder	Policy Holder
Policy Holders Address	Address
Policy Holders Phone# Work #	Phone # Work #
Policy Holders SS #	Policy Holders SS#
Policy Holders DOB	Policy Holders DOB
ID Number	ID Number
Do you have any other insurance Policies?	Yes No
Are you currently a full time student?	Yes No School:
Is this injury the result of an accident?	Yes No
Date of accident	
Ins. Co.	Claim #
Adjuster	Adjustor's Phone #
Address	

Referring Physician	Phone Number
Primary Care Physician	Phone Number
Date of Injury	**Surgery Yes No Date:**
Have you had PT this calendar year?	Yes No # of visits:
How Did you hear about us? **Doctor Friend/ Relative Former Patient Ad/ Phonebook Internet/webpage** **Other:**	
Who may we thank for your referral?	

Patient Signature

Date

Medical Screening Questionnaire

Date:_______________________Name:____

The following questions will assist us in the treatment of your condition and provide you with safe and effective treatment. Please check if you have ever been diagnosed with any of the following conditions

[ ] Anemia
[ ] Asthma
[ ] Cancer or Tumor.
[ ] Chemical Dependency
[ ] Depression
[ ] Diabetes
[ ] Fibromyalgia
[ ] Heart Disease.
[ ] High Blood Pressure
[ ] HIV or AIDS
[ ] Joint replacement or any other implants
[ ] Kidney Disease
[ ] Low Blood Pressure
[ ] Lyme Disease
[ ] Neurological Disorders (Please specify)
[ ] Osteoporosis
[ ] Peripheral Vascular Disease / Circulation problems.
[ ] Pulmonary Disease.
[ ] Rheumatoid Arthritis
[ ] Seizures / Epilepsy
[ ] Stroke or Aneurysm
[ ] Thyroid problems
[ ] Other major illness not listed: ____

For Office Use Only

Are you currently pregnant or think you might be? ___Yes ___No ___N/A

In the last 3 months or so, please check if you have noticed any of the following:

___ Fever, chills, or sweats
___ Excessive unexplained weight loss or gain
___ Loss of appetite, nausea, or vomiting
___ Difficulty sleeping
___ Fatigue, weakness
___ Chest pain
___ Shortness of breath
___ Dizziness or fainting
___ Numbness or tingling
___ Difficulty urinating/ changes in frequency of urination

Please list any and all medications you are currently taking (including ANY over-the-counter medications)
____
____
____

Please list any medication(s) you are allergic to:____

Are you allergic to Latex? ___Yes ___No

____ ____________

Patient Signature Date

Medical Screening Questionnaire

Please list previous surgeries or any other conditions for which you have been hospitalized in **5 years,** Include approximate dates.

____

____

____

Reason for today's visit: ____

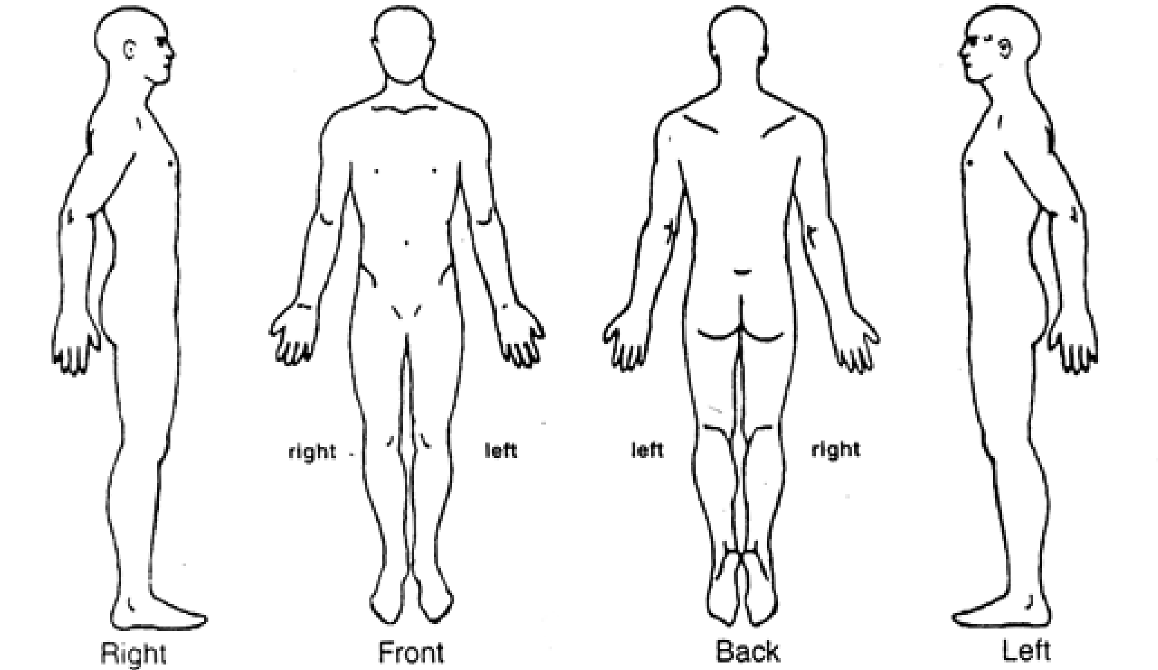
If you are currently seeing any other health care professionals for your **current condition**, please check that which applies:

___Medical Doctor (MD) ___Physical Therapist ___Psychiatrist/Psychologist
___Doctor of Osteopathy (DO) ___Chiropractor ___Other ______________________

Have you had any of the following tests preformed for the condition?

___X-Ray ___MRI ___CT Scan __EMG __Other ____________________

Please mark or shade the areas of your body where you feel pain on the diagrams below



Also please circle the number that corresponds to the severity of your pain at its worst:

No pain	Minimal	Tolerable, But Hinders Activities	High, 50% Of Activities Impaired	Extreme, Most Activities Impaired	Unbearable
0	1 2	3 4	5 6	7 8	9 10

_______________________________ ____________

Patient Signature Date

Certification Authorization and Patient Consent

I certify all information I have provided to PRO Physical Therapy is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance, Including but not limited to co-pays, any co-payments, deductibles and/or supply purchases.

I authorize PRO Physical Therapy, LLC to release any medical or other information acquired during my examination and/or treatment to any insurance company, employer, hospital or physician.

I assign/authorize payment of medical benefits to PRO Physical Therapy, LLC for all services rendered. PRO Physical Therapy, LLC does not accept responsibility for collecting on or negotiating the settlement of any legally disputed claim.

I authorize PRO Physical Therapy, LLC to render physical therapy services.

________________________________ __________________

Patient Signature Date

*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{sum of n responses}}{n} \right] - 1 \right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

Date: ______________________________

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Patient Guidelines

- In order to receive mazimum benefit from your rehabilitation program, it is of utmost importance that you attend your therapy appointments regularly and follow home instructions.

- We request that if you are unable to keep your appointments that you notify the office **24 hours** prior to your scheduled appointment.

- It is your responsibility to schedule your appointments **at least one week** in advance. (Failure to do so may result in your ideal time slot not being available.)

- Being **on time** for each appointment will insure that you will be seen that day and receive your full treatment.

- Please inform your therapist at least one week in advance of any physician appointments. This will allow us to send the appropriate communication ahead of time.

- Your are subject to be discharged from our services after three missed appointments (within a four-week period) or a three week absence.

- Your participation is appreciated. We look forward to working with you and obtaining the best possible results for you. If any questions come up, please don't hesitate to ask.

2 Emery Ave. Ste. 3, Randolph, NJ 07869, Phone: 973-895-9925 Fax: 973-895-9927