

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: _____

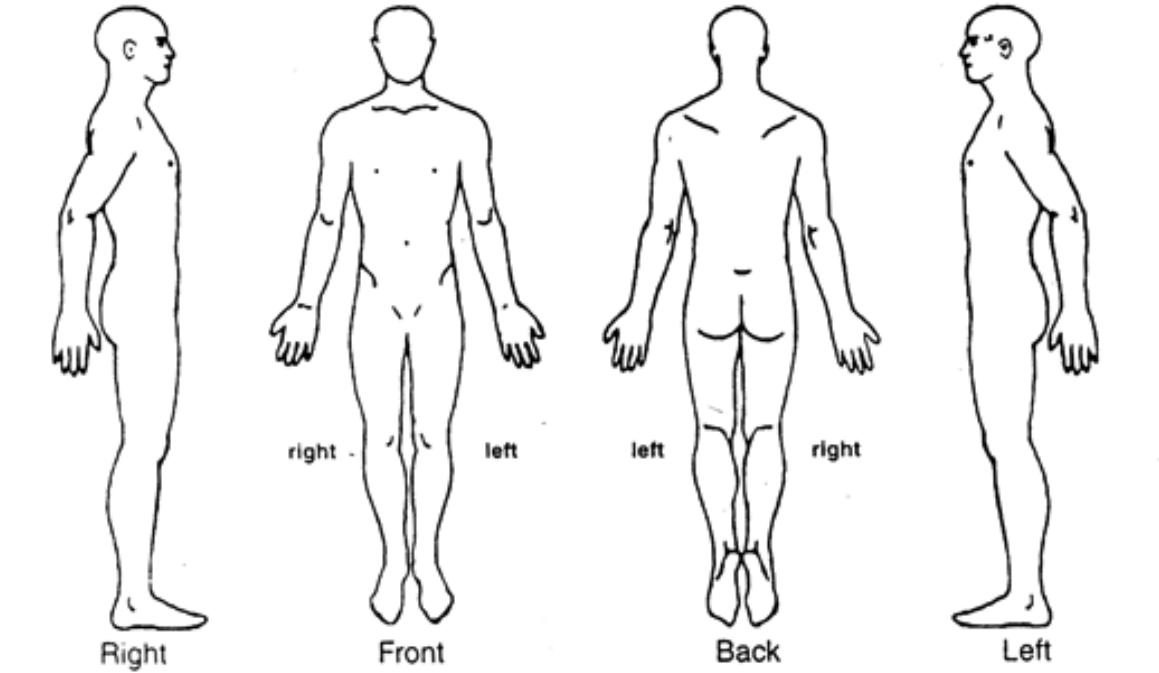
If you are currently seeing any other health care professionals for your **current condition**, please check that which applies:

Medical Doctor (MD) Physical Therapist Psychiatrist/Psychologist
 Doctor of Osteopathy (DO) Chiropractor Other _____

Have you had any of the following tests performed 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

Name: _____

Date: ____ / ____ / ____
mm dd yy

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark in the one box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but please mark only the box which most closely describes your current condition.

Pain Intensity

- I can tolerate the pain I have without having to use pain medication.
- The pain is bad but I can manage without having to take pain medication.
- Pain medication provides me complete relief from pain.
- Pain medication provides me with moderate relief from pain.
- Pain medication provides me with little relief from pain.
- Pain medication has no affect on my pain.

Personal Care (Washing, Dressing etc.)

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

Lifting

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

Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than ½ mile
- Pain prevents me from walking more than ¼ mile.
- I can only walk with crutches or a cane.
- I am in bed most of the time and have to crawl to the toilet.

Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Standing

- I can stand as long as I want without increased pain.
- I can stand as long as I want but increases my pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than ½ hour.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using pain medication.
- Even when I take pain medication, I sleep less than 6 hours.
- Even when I take pain medication, I sleep less than 4 hours.
- Evens when I take pain medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

Social Life

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

Traveling

- I can travel anywhere without increased pain.
- I can travel anywhere but it increases my pain.
- My pain restricts travel over 2 hours.
- My pain restricts my travel over 1 hour.
- My pain restricts my travel to short necessary journeys under ½ hour.
- My pain prevents all travel except for visits to the doctor/therapist or hospital.

Employment/Homemaking

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

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: _____



Patient Guidelines

- In order to receive maximum 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.
- You 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.