

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

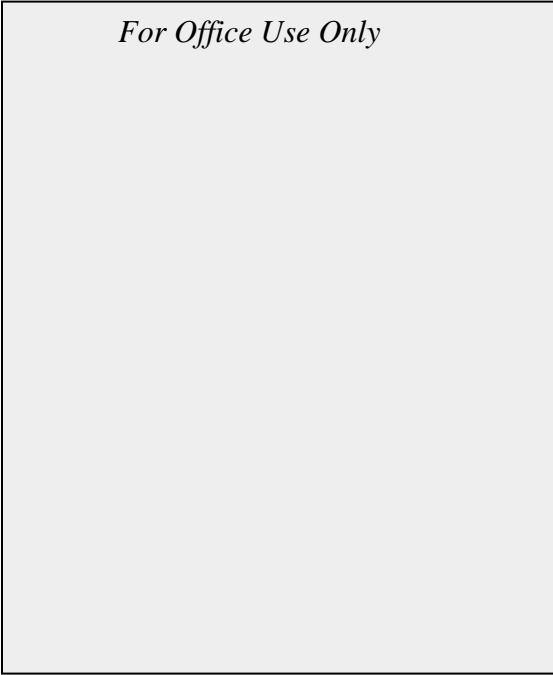
Date

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: _____



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: _____

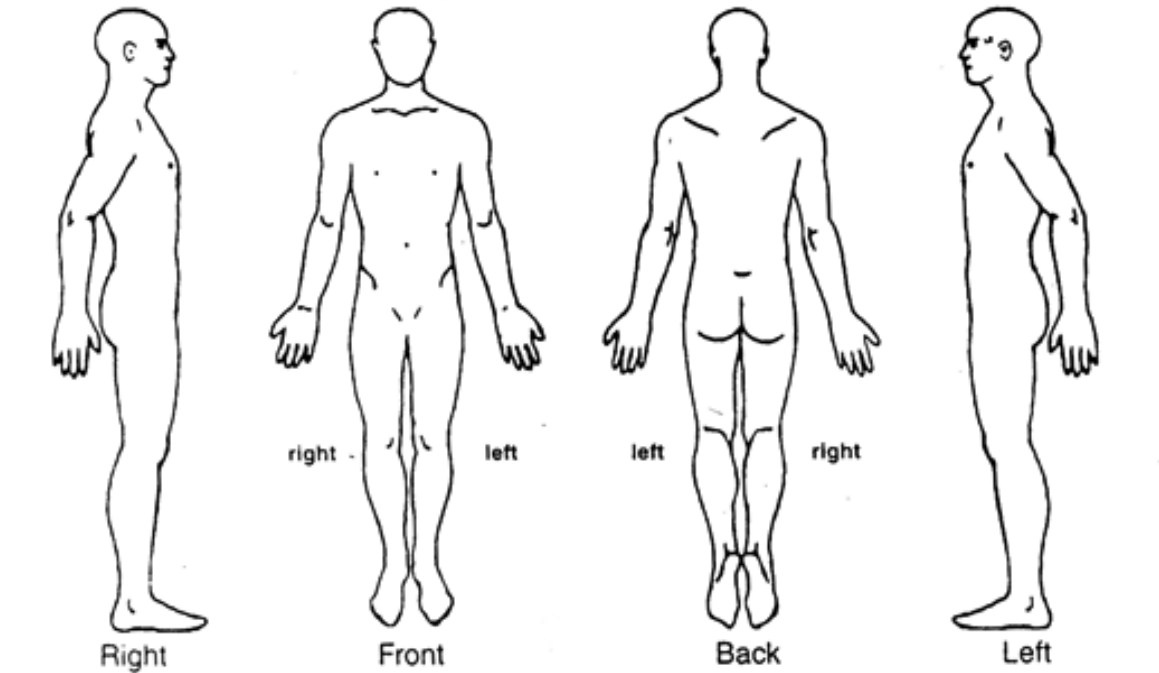
If you are currently seeing any other health care professionals for your **current condition**, please check that which applies:

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

Appendix 4. Neck Disability Index*

Name: _____

Date: ____/____/____
mm dd yy

This questionnaire has been designed to give your therapist information as to how your neck pain has affected you in your every day life activities. Please answer each section; marking only the ONE box which best describes your status today.

Section 1—Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2—Personal Care (Washing, dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes me extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

Section 3—Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example 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 cannot lift or carry anything at all.

Section 4—Reading

- I can read as much as I want with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

Section 5—Headache

- I have no headache at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all of the time.

Section 6—Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 7—Work

- I can do as much as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Section 8—Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

Section 9—Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleep loss).
- My sleep is mildly disturbed (1-2 hours sleep loss).
- My sleep is moderately disturbed (2-3 hours sleep loss).
- My sleep is greatly disturbed (3-5 hours sleep loss).
- My sleep is completely disturbed (5-7 hours sleep loss).

Section 10—Recreation

- I am able to engage in all of my recreational activities with no neck pain at all.
- I am able to engage in all of my recreational activities with some pain in my neck.
- I am able to engage in most, but not all, of my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I can't do any recreational activities at all.

*Adapted and reprinted from Vernon H, Mior S. The Neck Disability Index: a study of reliability and validity. *J Manipulative Physiol Ther.* 1991;14:409-415, with permission of Elsevier.

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.