Center for Physical Therapy and Wellness, PC

PATIENT INFORMATION

NAME: ______________________________ DATE OF BIRTH: ____________

(PARENT/GUARDIAN NAME IF PATIENT IS UNDER 18 YEARS OLD ____________________)

STREET ADDRESS: ______________________________

CITY: ____________________ STATE: __________ ZIP CODE: ____________

HOME PHONE (   ) ______________ CELL PHONE (   ) ______________

MALE ___ FEMALE ___ EMAIL ______________________________

EMPLOYER: ______________________ WORK PHONE (   ) ____________

ADDRESS: ______________________________

WHICH PHONE NUMBER IS THE BEST FOR CONTACTING YOU? HOME___ WORK___ CELL___

SPOUSE /PARTNER'S NAME: ________________ (CELL/WORK) ____________

WHO DO WE CONTACT IN CASE OF EMERGENCY? (OTHER THAN YOUR OWN HOME)

NAME: ________________ RELATION: __________ PHONE (   ) __________

DR. WHO REFERRED YOU TO PHYSICAL THERAPY: ______________________

PRIMARY CARE PHYSICIAN: ______________________________

PRIMARY ISURANCE CARRIER: ______________ (WE WILL NEED A COPY OF THE CARD)

SECONDARY INSURANCE CARRIER: ____________ (WE WILL NEED A COPY OF THE CARD)

HAVE YOU HAD ANY PRIOR PHYSICAL THERAPY OR CHIROPRACTIC CARE IN THE PAST YEAR? (IF YES, HOW MANY TREATMENTS?) ____________

MEDICARE PATIENTS ONLY:
HAVE YOU HAD ANY HOMECARE NURSING OR AIDES IN THE LAST YEAR? __________

IF***WORKERS COMPENSATION*** DATE OF ACCIDENT ____________________

EMPLOYER AT TIME OF INJURY ______________________________

EMPLOYER'S INSURANCE CARRIER ______________________________

CLAIM REPRESENTATIVE ____________________ PHONE# ______________

CLAIM # ______________________________

IF***AUTO ACCIDENT*** DATE OF ACCIDENT: ____________________

INSURANCE CARRIER ______________________________

CLAIM REPRESENTATIVE ________________ PHONE# ______________

CLAIM # ______________________

ATTORNEY ______________________ PHONE (   ) ______________

NAME: ______________________________ Referred by: ___________________________ DATE: _____________

Occupation and/or activities that comprise your day: ____

Age: Height: Weight: Do you live alone? Yes No

What date (roughly) did your symptoms begin? ____

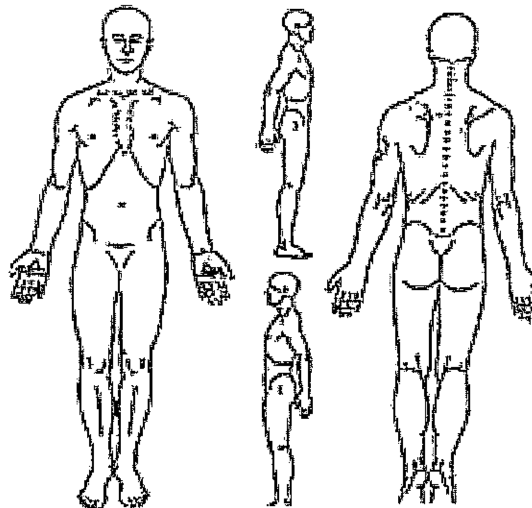
What do you think caused your symptoms? ____

Special tests received so far for this problem (i.e. x-ray, MRI, labs, etc): ________________________________

Treatment received so far for this problem (chiropractor, injections, medication, etc.) ____________________

Have you had this problem before? Yes No When____________________ treatment received ____________________

On the diagram, please mark the areas where you feel symptoms and describe your symptoms (i.e. numbness, tingling, dull ache, sharp pain...)



Please list aggravating factors:

Please list easing factors:

Are your symptoms: [ ] getting better, [ ] getting worse, [ ] not changing

SLEEP: [ ] No problem sleeping, [ ] Difficulty falling asleep, [ ] Awakened by pain, [ ] Can sleep only with medication

Do you smoke? Yes No Do you have a pacemaker? Yes No For Women: Are you pregnant? Yes No

Please list known ALLERGIES: ____ Are you latex sensitive? Yes No

Have you **RECENTLY** Noticed any of the following (please check all that apply):

o Fatigue	o Balance Difficulty	o Dizziness/lightheadedness	o Constipation/Diarrhea
o Fever/Chills/Sweats	o Falls	o Heartburn/indigestion	o Shortness of Breath
o Nausea/Vomiting	o Numbness or Tingling	o Difficulty swallowing	o Fainting
o Weight loss/gain	o Muscle Weakness	o Changes in bladder/bowel	o Headaches

Have you **EVER** been diagnosed with any of the following (check all that apply):

o Cancer	o Stroke	o Depression	o Thyroid Condition	o Ulcers
o Heart/Cardiac Condition	o Anemia	o Rheumatoid A.	o Diabetes	o Eye Pathology
o Chest pain/angina	o Bone infection	o Other Arthritis	o Osteoporosis	o Hepatitis
o High Blood Pressure	o Asthma	o Kidney Infection	o Multiple Sclerosis	o Liver Condition
o Circulation problems	o Lung Pathology	o Bladder Infection	o Epilepsy	o Alcoholism
o Blood Clots	o Tuberculosis	o STD/HIV	o Parkinson's	

Please list any other important past medical history (if not listed above): ________________________________

Please list any surgeries or recent hospitalizations, including dates: ________________________________

Pain Numeric Rating Scale

1. On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst pain imaginable, how would you rate your pain RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

2. On the same scale, how would you rate your USUAL level of pain during the last week.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

3. On the same scale, how would you rate your BEST level of pain during the last week.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

4. On the same scale, how would you rate your WORST level of pain during the last week.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

The Center for Physical Therapy and Wellness

Please list **all medications** that you take on a daily basis as well as medications you take on an "as needed" basis. These include **all prescriptions, over-the-counter, vitamins and supplements.** Please also list the **dosage** in milligrams and frequency at which you take the medication.

NAME OF MEDICATION	DOSAGE: AMOUNT (in milligrams)	DOSAGE: FREQUENCY (times per day)	WHAT IS THIS MEDICATION FOR?
PRESCRIPTION MEDICATIONS:			
OVER-THE-COUNTER MEDICATIONS:			
VITAMINS/SUPPLEMENTS:			

PATIENT'S INITIALS:	THERAPIST'S INITIALS:	DATE:

Center for Physical Therapy and Wellness, pc

Payment Information and Medical Release
(A copy of this will be provided to you at your request)

Insurance Billing and Payment
Please provide us with all of the information needed to process your claim with your insurer.

TREATMENT RENDERED WITHOUT PRIOR AUTHORIZATION IS THE PATIENT'S RESPONSIBILITY. We do not accept responsibility for incorrect information given to us by your insurance company. It is your responsibility to know your benefits.

We will do all we can to submit treatment plans or other information required for the start or continuation of treatment. The insurer may take a few days or weeks to process the request. You will be notified if your treatment has not been authorized. If the delay is unusually long, you may be given the option of continuing to schedule appointments with the understanding that you are responsible for services you receive that are not authorized. Your assistance in handling insurance or authorization problems may be needed and greatly appreciated.

You may receive a monthly statement if you have a balance on your account or there is an insurance issue, which requires your attention.

Finance Charges
A finance charge of one and one half (1.5%) per month with a maximum per annum charge not to exceed state and federal laws, will be charged on all past due statements. In case suit shall be brought for collection hereof, or the same has to be collected upon demand of any attorney, or collection service, the guarantor agrees to pay reasonable attorney fees or collection costs.

Cancellation and No-Show policy

- ☐ We require 8 business hours notice for cancelled appointments. If you fail to show for your appointment or you have repeated cancellations, this may be grounds for discharge with notification to your physician and/or attorney. There will be a $20.00 charge for no-shows or last minute cancellations.

Release of Medical Information
This authorization or photocopy thereof will authorize the representative of Center for Physical Therapy and Wellness, PC to release any information regarding my condition including pertinent medical history, clinical findings and prognosis to my insurer and/or attorney in order to facilitate the processing of my claim for physical therapy services.

Patient's Signature ______________________________ **Date**____________

CENTER FOR PHYSICAL THERAPY AND WELLNESS, p.c.

Acknowledge of Receipt of Notice of Privacy Practices, billing and Cancellation Policies.

This Form acknowledges that you have received and had an opportunity to ask questions concerning Center for Physical Therapy and Wellness' Notice of Privacy Practices, billing and cancellation policies.

I,________________________________, have received the Notice of Privacy Practices, Billing and Cancellation policies from Center for Physical Therapy and Wellness.

X__________________________________ Date:________________________