ADVANCED PHYSICAL THERAPY LLC

ORTHOPEDICS - SPINE - SPORTS MEDICINE

Patient Information

Last Name: __________________________ First Name: _______________________ M I: _____ M/F _____

Address: ____ City/State/Zip _____________________________

Home Phone #: __________________________ Cell Phone #: _____________________________________

Date of Birth: ____________ SS#: _________________ Referring Physician: ___________________________

Primary Care Physician, if other than referring Physician: ____

Employer: _________________________Occupation:______________________Work Phone: ____________

Emergency Contact: ___________________ Phone #: ________________Relationship to Insured: _________

Email Address:____

**********************************BILLING INFORMATION************************************

Related to Work Injury or Automobile - Yes or No: _________If Yes, Date of Injury: ____________________
Claim #: ___________________________ Person to contact: ____
For Auto claims – Do you have MedPay on Policy? Yes / No / Unsure

IF OTHER THAN ABOVE:
Relationship to the Insured for Primary Insurance: Self Spouse Child Other
Insured's Employer _____________________________________
Relationship to the Insured for Secondary Insurance: Self Spouse Child Other
Insured's Employer _____________________________________
Are you presently receiving Home Health Care? (Yes or No) i.e. home companion, visiting nurse
Name of Agency _______________________________________
Have you recently finished Home Health Care? (Yes or No)
Name of Agency _______________________________________

Primary Insurance: ___________________________________ Policy #: _________________________
Primary's Name and DOB: ____
Secondary Insurance: __________________________________Policy #: _________________________
Secondary's Name and DOB: ____

HIPAA

I have been offered a copy of the notice of privacy practices and have accepted or denied the offer. I give my consent that my health information can be used for the purpose of treatment, payment, and health care operations.
Signature: ____ Date: ________________________

************************************PAYMENT POLICY************************************

I authorize payment to be made and/or sent directly to Advanced Physical Therapy. I agree to be responsible for any unpaid balances for services rendered. I agree to pay my deductible and/or copayment upon each visit. I understand that obtaining any necessary insurance referrals from my referring physician is my responsibility. Durable goods are to be paid for at the time received (i.e. braces, orthotics, etc). If the bill is sent to our collections agency, I further agree to pay the cost of collections. This includes all reasonable attorneys' fees for all unpaid bills submitted. All unpaid bills, beyond 60 days, may have an interest rate of 1.5% per month.

Signature: ____Date: ____________________
How did you hear about us? ____

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PATIENT MEDICAL SCREENING QUESTIONNAIRE

Have you had surgery for this injury? Yes No Number of surgeries: 1 2 3 4 5 6

Type of surgery: _____

List of your **current** prescription and/or non-prescription medications: _____

_____

Height:_____ Weight:_____ Typical Blood Pressure (if known)_____

Have you had any of the following medical or rehabilitative services for **this** injury or episode?

	YES	NO		YES	NO
Physical Therapy	_____	_____	MRI	_____	_____
Massage Therapy	_____	_____	X-rays	_____	_____
Chiropractic	_____	_____	CT scan	_____	_____
Podiatrist	_____	_____	EMG/NCV	_____	_____
Neurologist	_____	_____	Injections	_____	_____
Orthopedist	_____	_____	Other _____		

Do you **NOW** have ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	_____	_____	Severe or frequent headaches	_____	_____
Shortness of breath/chest pain	_____	_____	Numbness or tingling	_____	_____
Dizziness or Fainting	_____	_____	Increased pain at night	_____	_____
Bowel or Bladder Changes	_____	_____	Changes in appetite	_____	_____
Weakness/Energy Loss	_____	_____	Pain after eating	_____	_____
Weight Loss/Gain	_____	_____	Are you pregnant?	_____	_____
Depression/Anxiety	_____	_____	Do you smoke?	_____	_____

Have you **EVER** had **ANY** of the following?

Coronary heart disease or Angina	_____	_____	Vision or hearing difficulties	_____	_____
Do you have a pacemaker?	_____	_____	Hernia	_____	_____
Heart Attack/surgery	_____	_____	Varicose Veins	_____	_____
Stroke/TIA	_____	_____	Allergies	_____	_____
Lung Disease	_____	_____	Poor Balance/Falls	_____	_____
High Blood Pressure	_____	_____	Joint replacement surgery	_____	_____
Blood clot/Emboli	_____	_____	Neck injury/surgery	_____	_____
Infectious disease	_____	_____	Back injury/surgery	_____	_____
Cancer/Type _____	_____	_____	Shoulder injury/surgery	_____	_____
Gout	_____	_____	Knee injury/surgery	_____	_____
Epilepsy/Seizures	_____	_____	Elbow/hand injury/surgery	_____	_____
Thyroid Disease or Goiter	_____	_____	Ankle/foot injury/surgery	_____	_____
Anemia	_____	_____	Any pins or metal implants	_____	_____
Diabetes/Type_____	_____	_____	Arthritis/Where?	_____	_____
Sleeping Difficulties	_____	_____	Osteoporosis	_____	_____

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes / No

During the past month, have you often been bothered by little interest or pleasure doing things? Yes / No

Is this something with which you would like help? Yes / Yes but not today / No

Patient/Guardian Signature: _____ Date: _____

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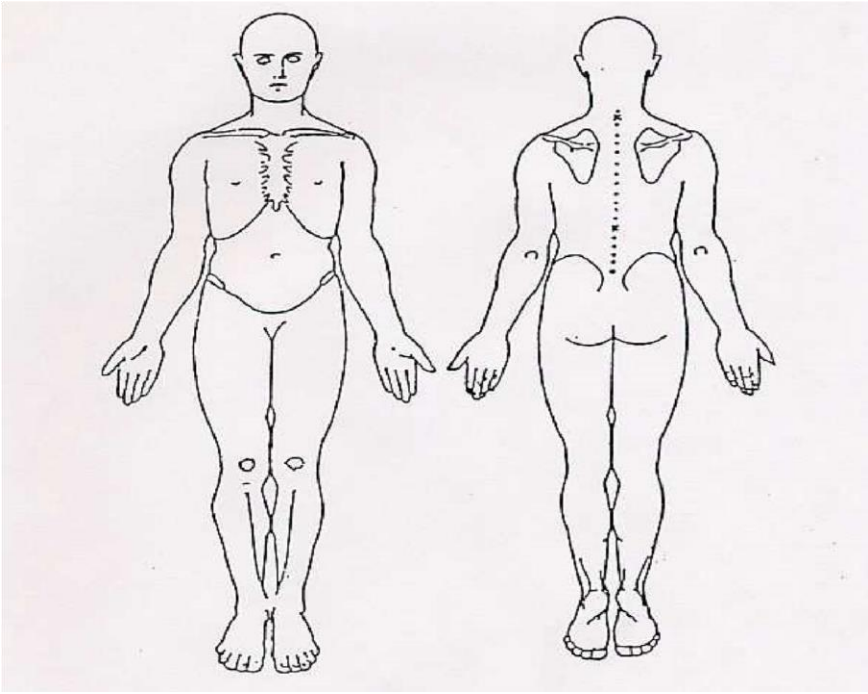
PAIN ASSESSMENT FORM



Please mark the areas where you feel pain in the picture above

Circle the word that describes your pain: Sharp Burning Ache Numbness Tingling Throbbing

What aggravates your pain: _____

What relieves your pain: _____

Rate Your Pain Below:	0=No pain										10=Worst Imaginable
At its worst in the past 3 days	0	1	2	3	4	5	6	7	8	9	10
Right Now	0	1	2	3	4	5	6	7	8	9	10
At its best in the past 3 days	0	1	2	3	4	5	6	7	8	9	10

Do you feel you have been made aware of your diagnosis? Yes / No Based on your awareness, what are your goals and expectations from physical therapy? _____

_____

List any other information that would assist us in your care: _____

_____

Do you have a history of falls in the past year? Yes / No

Patient/Guardian Signature: _____ Date: _____