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: __________________________________________

Email Address:_________________________________________________________________________

Employer: _________________________Occupation:______________________Work Phone: ____________

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

*******************************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 or recently finished **Home Health Care**? (Yes or No) i.e. visiting nurse, etc
Name of Agency _______________________________________ Discharge Date: _______________

Have you received **any other physical therapy services** within your insurance plan year? Y or N

**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: ____________________

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Please circle **ALL** the ways in which you heard of us?
***Internet search / Friend / MD referral / Newspaper ad / Facebook / Community Event / Drive-by***

Is there someone or a specific event that we can thank for the referral:______________________________

**Have you had surgery for this injury?**_______ If Yes, what 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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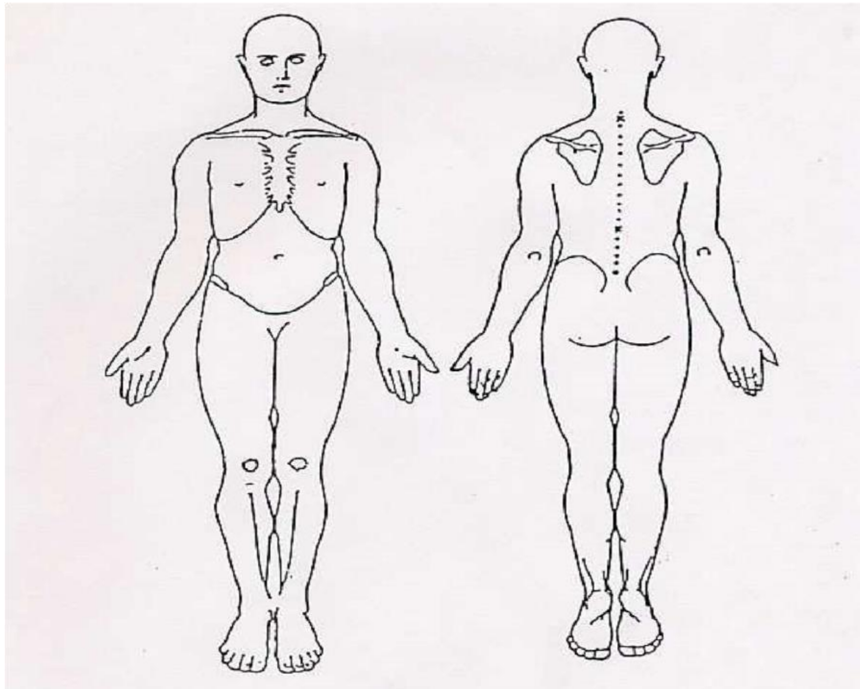
# PAIN ASSESSMENT FORM



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: ______________