PPT-Booneville

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____

Latest Referral Information _____ Motor Vehicle Accident _____

Latest Plan of Care _____ That occurred in: _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Tertiary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

Patient History Questionnaire

Date: _____

Name: _____ DOB: _____

Pain/Injury Description

What is your main complaint (Why were you referred for physical therapy)? _____

_____

Describe your level of function **before** pain/injury: **Normal** **Restricted** Please Specify_____

Check any of the following activities which you **currently** have difficulty with due to your pain/injury:

____Housekeeping ____Lifting ____Driving ____Shopping ____Reaching

____Dressing ____Cooking ____Climbing Stairs ____Child Care ____Bending

____Yard Work ____Sit to Stand

Other limitations: _____

Rating - Please rate your pain using **a 0 – 10 scale** (0 = No pain, 10 = the worst pain that you can imagine)

Worst pain since onset: _____ **least** pain since onset: _____ **Current** pain: _____

What have you been doing to decrease your pain? _____

Have you had any injections for your pain/injury? Yes____ No____ If so , When? _____

Have you had physical therapy for your pain/injury? Yes____ No ____ If so, When?_____

Please circle the tests you have had performed for your pain/injury:

None X Rays MRI CT Scan Bone Scan Other (Explain) _____

Check all of those which apply to your current condition:

____Work Related Injury ____Sports Injury ____Fall

____Surgery ____Aggravation of Pre-Existing Injury ____Cause Unknown

____Injury Recurrence ____Motor Vehicle Accident ____Lifting Injury

____Other:_____

Medical History

	Yes	No		Yes	No		Yes	No
Diabetes	____	____	**Cancer**	____	____	**Metal Implants**	____	____
Chest Pain	____	____	**Asthma**	____	____	**Dizziness**	____	____
Heart Disease	____	____	**Arthritis**	____	____	**Fractures**	____	____
High Blood Pressure	____	____	**Aids/HIV**	____	____	**Skin Allergies**	____	____
Respiratory Problems	____	____	**Allergies to Heat**	____	____	**Nausea/Vomiting**	____	____
Kidney Problems	____	____	**Allergies to Cold**	____	____	**Ear Ringing**	____	____
Are You Pregnant	____	____	**Seizures**	____	____	**Hypoglycemia**	____	____
Bladder Problems	____	____	**Headaches**	____	____	**Pacemaker**	____	____

List any medications you are taking: _____

_____

What type of non-work/physical activities/sports are you involved in? _____

Is there any other information about your present health that we should know about? _____

_____

Have you received therapy from a Home Health Care Facility or had Physical Therapy, Speech Therapy or Occupational Therapy this calendar year? ___Yes ___No

CONSENT TO TREAT/ASSIGNMENT OF INSURANCE INFORMATION/RELEASE OF MEDICAL INFORMATION/PRIVACY POLICY

Performance Physical Therapy, Inc. appreciates you choosing us for your therapy services. Our therapy clinic has the following policies:

I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist/physical therapist assistant employed by or under contract with Performance Physical Therapy, Inc.

I authorize that all benefits by my insurance company be paid directly to Performance Physical Therapy, Inc., and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. I authorize release of information needed by my insurance to secure payment. I understand that there will be a $40.00 fee for checks returned to you as unpaid by my bank.

Patients will be required to pay their copay and/or deductible at each visit.

If any patient owes a prior unpaid balance on a previous case, 50% is due before any future visits can be made.

In addition, I hereby authorize the release of all applicable medical information including & without limitation, copies of all records to other health care providers that I may be referred to for subsequent treatment in connection with care provided by Performance Physical Therapy, Inc. If physical therapy pertains to a workman's compensation claim, in addition to the above statement, I also authorize my information to be released to my employer.

I acknowledge that I have received Performance Physical Therapy, Inc. Notice of Privacy Practices for Protected Health Information.

I give permission to release my information to the following if requested:

_____

_____

Date: _____ Name of Patient: _____
Print Name

_____
Signature of Patient/Guardian

REVISED 1/4/16