Performance Physical Therapy

PATIENT INFORMATION FORM

Social Security #	First Name	MI	Last Name	Sex M/F	DOB / /

Home Telephone # ( )	Best Contact Telephone # ( )	E-mail Address	Marital Status

Address (Street)	PO Box	City	State	Zip Code

Emergency Contact Name	Emergency Contact Phone # ( )	Relationship to Patient

Current Employer	Employer Telephone # ( )	Policy Holder's Social Security #

Policy Holder's Name	Policy Holder's DOB / /	Policy Holder's Employer

Have you received services from a home health agency within the last 30 days? YES NO	Have you received any outpatient physical therapy this year? YES NO	Current Work Status (Circle One) Full Part Student Retired

PAYMENT AND INSURANCE FILING

Payment Policy

Payment is requested at the time of service unless other arrangements are made prior to treatment. Payment may include a co-pay or estimated patient balance depending on your insurance type. Payment can be made by cash, check, MasterCard, Visa, Discover, American Express or Care Credit.

Insurance Filing

Performance Physical Therapy (PPT) will file your primary and secondary insurance if you provide the appropriate insurance information. You will receive a statement each month if your account has a balance and you are responsible for the payment of that balance.

Our participation in an insurance program is not a guarantee of payment from your insurance. You will receive a statement for any balance after insurance has responded to our claim. If your insurance does not pay, you should contact your insurance company. PPT will NOT negotiate the settlement of a disputed insurance claim.

Legal Cases

PPT cannot treat patients on a contingency basis; therefore, where legal cases are pending settlement, we ask that the full charge be paid at the time treatment is rendered unless prior arrangements for payment have been made.

CONSENT FOR TREATMENT AND AUTHORIZATION

I do hereby consent for treatment at Performance Physical Therapy. I authorize PPT to release medical and supporting documentation of same as compiled in my medical record during this treatment or subsequent treatments for purposes of benefit payment. I further authorize my insurance benefits to be paid directly to PPT, PC when indicated on claim. I understand I am financially responsible for the services I received.

Signed:____ Date:_____________

Relationship to Patient:____________________ Witnessed by:___________________________________

CANCELLATION & PRIVACY POLICIES

CANCELLATION POLICY

Your appointment time is important to you, your physical therapist and to others who are in need of our services. The following policy is in place to ensure everyone receives timely uninterrupted care.

- For cancellations please call us at least **24 hours** prior to your appointment time.
- There is a **$25.00 fee** charged if you do not attend your appointment and do not call to cancel at least 24 hours prior to your appointment time.
  - Future appointments will not be made until this fee is paid.
  - This fee is your personal responsibility and will not be billed to or paid by your insurance company
- If you are **more than 10 minutes late** for your appointment and there is not sufficient time left to complete your treatment, you may be asked to reschedule.

By signing below you acknowledge that you have read and understood this cancellation policy and agree to comply with it as written.

COMMUNICATION RELEASE

1. I hereby give permission to the PPT office staff to notify me for: (Check all that apply)

☐ Appointment changes by either personal message, recorded message or e-mail

☐ Appointment reminders by e-mail.

2. The individual(s) listed below is/are authorized to receive the above information on my behalf:

____________________________ ____________________________

____________________________ ____________________________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICY

By signing below I confirm that I have received and reviewed a copy of the Notice of Privacy Practices from Performance Physical Therapy and understand the information as outlined.

By signing below I agree to the above statements and verify that the above information is accurate to the best of my knowledge.

Signed:____ Date:______________

Relationship to Patient:______________ Witnessed by:____________________________________

Performance Physical Therapy

Name:______________________________

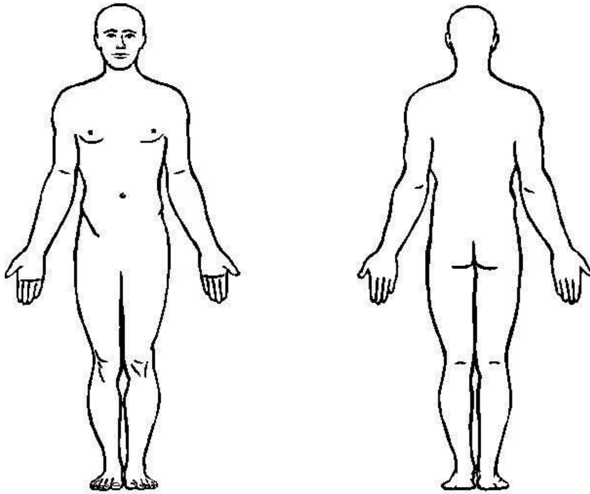
Date of Birth:___________________

CURRENT COMPLAINTS

1. Please indicate the body part(s) to be treated today.
   ☐ Left ☐ Right

   ☐ Neck ☐ Shoulder ☐ Elbow ☐ Wrist/Hand
   ☐ Back ☐ Hip ☐ Knee ☐ Ankle/Foot
   ☐ Other:_______________

2. On the diagram below please indicate where you are currently having pain:



3. When did the problem begin (date of injury)?
   ____

4. How did it happen?
   a. Injury? ☐ Yes ☐ No ☐ Unknown
   b. How did the injury occur?
      ☐ Accident ☐ Fall ☐ In competition
      ☐ Other ________________________
   c. Where did the injury occur? ☐ Work ☐ Home
      ☐ Other _______________________________
   d. Surgery Performed? ☐ Yes ☐ No
      Date of surgery:_________________________

5. Have you had this problem(s) before? ☐ Yes ☐ No
   a. What did you do for the problem(s)?
      ☐ Physical Therapy ☐ Medication ☐ Physician
      ☐ Chiropractor ☐ Other ______________
   b. Did the problem(s) get better? ☐ Yes ☐ No
   c. How long did the problem(s) last?_____________

6. Have you had any of the following tests for your current problem?
   ☐ X-rays ☐ CT Scan ☐ MRI
   ☐ Bone Scan ☐ Nerve Conduction Study

7. Do you currently use any of the following?
   ☐ Cane ☐ Glasses ☐ Crutches
   ☐ Hearing Aid ☐ Walker ☐ Brace
   ☐ Pacemaker ☐ Wheelchair (Motor/Manual)
   ☐ Other:______________

8. Are you seeing anyone else for the problem(s)?
   ☐ Acupuncturist ☐ Orthopedist
   ☐ Cardiologist ☐ Osteopath
   ☐ Chiropractor ☐ Podiatrist
   ☐ Family Practitioner ☐ Psychologist/Counselor
   ☐ Internist ☐ Physiatrist
   ☐ Massage Therapist ☐ Rheumatologist
   ☐ Neurologist ☐ Other _____________
   ☐ Ob/Gyn

9. Please list three activities that are difficult for you because of this current injury:
   1. ____
   2. ____
   3. ____

10. PLEASE USE THE PAIN SCALE TO ANSWER THE FOLLOWING QUESTIONS (*Circle one number for each*):

   a. What is your pain level NOW? *No Pain* 0__1__2__3__4__5__6__7__8__9__10 *Worst Possible Pain*
   b. Pain at its WORST in the last week? *No Pain* 0__1__2__3__4__5__6__7__8__9__10 *Worst Possible Pain*
   c. Pain at its BEST in the last week? *No Pain* 0__1__2__3__4__5__6__7__8__9__10 *Worst Possible Pain*

PATIENT/GUARDIAN SIGNATURE: ____ DATE:__________________

PHYSICAL THERAPIST SIGNATURE:____________________________LICENSE #:_________ DATE:________________

Performance Physical Therapy

Name:______________________________

Date:______________________

MEDICAL/SOCIAL HISTORY FORM

Please complete the following form to the best of your knowledge. If you are a returning patient you will be asked to complete this form once every **six months** to keep our records current.

MEDICAL HISTORY

1. Do you have any allergies? ☐ Yes ☐ No
   a. If yes, please list: ____________________

2. Please check if you have ever had any of the following:

- ☐ Alzheimer's disease
- ☐ Arthritis
  - Type:________________
- ☐ Blood disorders
- ☐ Broken bones/fractures
- ☐ Cancer
  - Type: ________________
- ☐ Chemical dependency
- ☐ Circulation problems
- ☐ Depression
- ☐ Diabetes/High blood sugar
  - ☐ Type I Diabetes
  - ☐ Type II Diabetes
- ☐ Head Injury
  - Type:________________
- ☐ Heart problems
  - Type:________________
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Low blood sugar
- ☐ Latex allergy
- ☐ Lung problems
  - Type: ______________
- ☐ Multiple sclerosis
- ☐ Osteoporosis/Osteopenia
- ☐ Parkinson's disease
- ☐ Repeated infections
- ☐ Stroke
- ☐ Seizures/epilepsy
- ☐ Skin diseases
  - Type: ______________
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers/stomach problems
- ☐ Other:______________

3. Have you recently had any of the following symptoms?

- ☐ Bowel/bladder problems
- ☐ Chest pain
- ☐ Coordination problems
- ☐ Difficulty swallowing
- ☐ Dizziness/Lightheadedness
- ☐ Fatigue
- ☐ Fever/chills/sweats
- ☐ Loss of appetite
- ☐ Loss of balance
- ☐ Nausea/vomiting
- ☐ Pain at night
- ☐ Shortness of breath
- ☐ Unexplained weakness
- ☐ Unexplained weight loss/gain

4. Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

CLINICAL TESTS

1. Within the past year, have you had any of the following tests? (Check all that apply.)

- ☐ Angiogram
- ☐ Biopsy
- ☐ Bone Density Scan
- ☐ CT Scan
- ☐ Doppler Ultrasound
- ☐ Echocardiogram
- ☐ EKG (electrocardiogram)
- ☐ EMG (electromyogram)
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ Nerve Conduction Test
- ☐ Pulmonary Function Test
- ☐ Stress Test
- ☐ X-rays
- ☐ Other:______________

MEDICATION

1.. Please list any prescription medications you are currently taking and their dosages. (a separate list may be provided)

MEDICATION NAME	DOSAGE	REASON FOR TAKING

2. Please indicate if you are taking any of the following over the counter medications:

- ☐ Aspirin
- ☐ Tylenol
- ☐ Advil/Motrin/Ibuprofen
- ☐ Antacid
- ☐ Laxatives
- ☐ Vitamins/Mineral Supplements
- ☐ Decongestants
- ☐ Antihistamines
- ☐ Other:____________________________

For Office Use

SURGERY / HOSPITALIZATIONS

1. Have you ever had surgery? ☐ Yes ☐ No

2. Please list approximate dates and reasons for any surgery or other conditions (including childbirth) that required hospitalization: *(a separate list may be provided)*

Date	Reason for hospital stay
__________	__________________________________
__________	__________________________________
__________	__________________________________
__________	__________________________________
__________	__________________________________

SOCIAL HISTORY

Work Status

1. Employment / Work (Job / School / Play)
   ☐ Working full-time ☐ Working part-time
   ☐ Regular duty ☐ Light duty

2. Occupation: _________________________________

   ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled

Cultural / Religious

1. Are there any customs or religious beliefs or wishes that might affect your care? ☐ No ☐ Yes

   a. Please explain:________________________________

Social/Health Habits

1. Smoking
   a. Do you currently use tobacco products? ☐ Yes ☐ No
   If yes: ☐ Cigarettes ☐ Cigars/Pipes ☐ Smokeless
   How many packs/day:__________________
   If no: Have you used tobacco in the past? ☐ Yes ☐ No
   Year Quit:______________

2. Alcohol
   a. How many days per week do you drink beer, wine or other alcoholic beverages? ____________________

   b. If 1 beer, 1 glass of wine or 1 cocktail equals 1 drink, how many drinks do you have in average week? ________

3. Caffeine
   a. How much caffeinated coffee or caffeine containing beverages do you drink per day?________________

4. Exercise
   a. Do you exercise regularly?
   ☐ Yes Type: ____________________________
   ☐ No
   b. On average, how many days per week do you exercise? _______________________________
   c. For how many minutes, on an average day? _________

2. In the past month have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

3. During the past month have you lost interest or pleasure in doing things you used to enjoy? ☐ Yes ☐ No

7. General Health Status. Please rate your health:
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Living Environment

1. With whom do you live?
   ☐ Alone ☐ Spouse only
   ☐ Spouse and others ☐ Child (not spouse)
   ☐ Other relative(s) ☐ Group Setting
   ☐ Personal Care Attendant
   ☐ Other:____________________

Other

1. Primary Language:
   ☐ English ☐Other:______________________
   Do you need an interpreter ☐ Yes ☐ No

2. Learning Barriers
   ☐ None ☐ Vision
   ☐ Hearing ☐ Unable to read
   ☐ Unable to understand what is read
   ☐ Other _________________________________

For Office Use

Patient/Guardian Signature: _______________________________________Date: ___________

Physical Therapist Signature: _____________________License #:_________ Date: ___________