PHYSICAL THERAPY CENTRAL

PATIENT INFORMATION

Patient Name: _____ **Birthdate:** _____ **Age:** _____

Address: _____ **Home Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Cell Phone:** _____

Employer: _____ **Work Phone:** _____

Preferred Contact Method for Appointment Reminders: ☐Home Phone ☐Cell Phone ☐Text Message

Email Address: _____ **Soc. Sec.#** _____

Please keep in mind that communication via email over the Internet is not a secure form of communication.

By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed **Spouse's Name:** _____

Financial Responsibility: ☐Self ☐Other (If Other, please complete Guarantor Assignment Form)

Emergency Contact: _____ **Phone:** _____ **Relation:** _____

PCP/Referring Physician: _____ **Referred to PTC by:** _____

Have you had Home Health Care in the last 30 days? ☐Y ☐N Home Health provider: _____

Have you had physical therapy treatment since January of this year? ☐Y ☐N # of visits _____

Have you had chiropractic treatment since January of this year? ☐Y ☐N # of visits _____

I hereby authorize and consent to treatments/services for myself, or on the behalf of the above named patient, performed by the staff at Physical Therapy Central (PTC) and/or as directed by my referring services.

Patients Signature: _____ **Date:** _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Policy#_____ Group#_____

Secondary Insurance Carrier: _____Policy#_____ Group#_____

*****A copy of your insurance card(s) will be kept on file. It is the patient's responsibility to provide PTC current insurance information.

Is this physical therapy care the result of an injury related to an Auto Accident, 3rd Party incident or Employment? ☐Y ☐N

**If YES, please fill out the Accidental Injury Questionnaire

AUTHORIZATION

I assign payment to PTMS 3.0, LLC. and authorize the filing of claims to my insurance company for payment of services rendered. I am fully aware that I am ultimately responsible for deductibles, co-pays, co-insurance and non-covered services. I authorize PTMS 3.0, LLC. to release any information acquired in the course of my treatment necessary to process insurance claims or to discuss my treatment with other practitioners.

By providing your contact information, you agree to receive information, such as appointment reminders, patient surveys, and other information relating to your therapy services via the communication channels you provided above.

My signature below also acknowledges receipt of PTMS 3.0, LLC. Notice of Privacy Practices (effective 01/01/2018).

Patients Signature: _____ **Date:** _____

If you do not have personal health insurance OR you do not want PTMS 3.0, LLC to file claims to your personal health insurance, please read and sign below:

I have asked PTMS 3.0, LLC. to **NOT** file claims to my personal health insurance carrier. If I decide at a later date to have PTMS 3.0, LLC. send claims to my personal health insurance carrier, I understand PTMS 3.0, LLC. will only do so at its discretion because possible contract obligations, per-certifications, per-authorizations, etc., may not have been performed, which would prohibit the likelihood of benefit coverage of my services. I understand and accept responsibility for full payment of any unpaid claims.

Patients Signature: _____ **Date:** _____

PHOTO/VIDEO AUTHORIZATION RELEASE

I grant to Physical Therapy Central and its affiliated entities, and its representatives and employees (collectively the “Company”) the right to take photographs and\or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation, therefore I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization. **AGREE** **DECLINE**

Patient Signature: _____ Date:_____

Parent/Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICE

(Patient/Representative Initials) _____ I acknowledge that I have received the practice/clinic’s Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider’s business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic’s Notice of Privacy Practice/ clinics.

Patient Signature: _____ Date:_____

Parent/Guardian Signature: _____ Date: _____

For questions or complaints, please contact:
Compliance Department
Toll free: 888-937-4479

Patient Name:_____

PATIENT HEALTH QUESTIONNAIRE

Occupation: _____

Leisure Activities: _____

Height: _____ Weight: _____ Age: _____

Are you currently experiencing or do you have any of the following:

Allergies	□Yes	□No	Seizures	□Yes	□No
Anemia	□Yes	□No	Speech Problems	□Yes	□No
Anxiety or Panic Disorders	□Yes	□No	Stroke/TIA	Yes	□No
Asthma	□Yes	□No	Thyroid Disease	□Yes	□No
Cancer	□Yes	□No	Tuberculosis	□Yes	□No
Site:_____			Vision Problems	□Yes	□No
Cardiac Conditions	□Yes	□No	Pacemaker	□Yes	□No
Chemical Dependency	□Yes	□No	Spinal Cord Stimulator	□Yes	□No
Cardiac Pacemaker	□Yes	□No	Lung Disease	□Yes	□No
Currently Pregnant	□Yes	□No	Blood Clots	□Yes	□No
Depression	□Yes	□No	Autoimmune Disease	□Yes	□No
Diabetes	□Yes	□No	Type:_____		
Dizzy Spells	□Yes	□No	Stomach Ulcers	□Yes	□No
Emphysema/Bronchitis	□Yes	□No	HIV	□Yes	□No
Fractures	□Yes	□No	Recent fever, chills, sweats	□Yes	□No
Gall Bladder Problems	□Yes	□No	Ringing in ears	□Yes	□No
Gastro Intestinal Disease	□Yes	□No	Hearing Loss	□Yes	□No
Heart Attack	□Yes	□No	Nausea Vomiting	□Yes	□No
Hepatitis	□Yes	□No	Headaches	□Yes	□No
Type:_____			Difficulty Swallowing	□Yes	□No
High Blood Pressure	□Yes	□No	Unexplained Weight Changes	□Yes	□No
Incontinence	□Yes	□No	Pain wakes me at night	□Yes	□No
Kidney Disease/Problems	□Yes	□No	Chest Pains - Angina	□Yes	□No
Metal Implants	□Yes	□No	Cough	□Yes	□No
Multiple Sclerosis	□Yes	□No	Shortness of Breath	□Yes	□No
Osteoporosis	□Yes	□No	Bowel or Bladder Disorder	□Yes	□No
Osteoarthritis	□Yes	□No			
Parkinson's	□Yes	□No	**Social History/ Wellness**		
Peripheral Vascular Disease	□Yes	□No	Do you drink alcoholic beverages?	□Yes	□No
Prosthesis/ Implants	□Yes	□No	Do you use tobacco?	□Yes	□No
Rheumatoid Arthritis	□Yes	□No	Do you exercise regularly?	□Yes	□No

List current medications (including prescription, over-the-counter, and herbal):

	Name	Dosage	Frequency	Administration
1.	_____	_____	_____	Oral, Patch, Topical, Other
2.	_____	_____	_____	Oral, Patch, Topical, Other
3.	_____	_____	_____	Oral, Patch, Topical, Other
4.	_____	_____	_____	Oral, Patch, Topical, Other
5.	_____	_____	_____	Oral, Patch, Topical, Other

Surgery / Hospitalization: Include date and reason

1. _____ 2. _____
3. _____ 4. _____

Patient Name:_____

1. List any known allergies (include medications, latex, etc): _____

2. List the dates and results of any X-rays: _____
   MRI: _____
   Bone Density test: _____
   Nerve Conduction test: _____
   Other: _____

3. Please rate your **current** pain on the line below:
   0……5……10

4. On a scale from 0-10 (0 = no pain; 10 = worst pain imaginable), what is the **worst** your pain has been in the past several days? _____/10. What is the **best** your pain has been? _____/10

5. Do you have any numbness, tingling, or burning? □Yes □No Constant or Intermittent

6. When did this problem first begin? _____/_____/_____ (Approximate date)

7. How did this problem begin? _____

_____

8. Have you ever had this problem before? □Yes □ No How many times? _____

9. Are your symptoms worse in? □ Morning □ Afternoon □ Evening □ Night □ Same all day

10. How are you able to sleep at night?
    □ Fine □ Moderate difficulty □ Only with medication □ Change positions all night

11. My pain/problem is slowly getting: □ worse □ better □ staying the same

12. My symptoms bother me: □ constantly 100% □ most of the time 75% □ occasionally 50% □ once in a while 25% or less

13. How often have you completed a least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? □ At least 3 times per week □ 1-2 times a week □ Seldom or Never

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

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

16. How many times have you fallen in the past 12 months? _____ Did it result in an injury? □Yes □No

17. This is a statement other patients have made. "***I should not do physical activities which (might) make my pain worse***." Please rate your level of agreement with this statement below. (Circle number)

0	1	2	3	4	5	6
Completely Disagree			Unsure			Completely Agree

Please provide your email so we can send your home exercise program: _____

Please keep in mind that communication via email over the Internet is not a secure form of communication.

PATIENT'S SIGNATURE: _____ DATE: _____/_____/_____

Patient Name:_____

Please indicate your current symptoms on the diagram below:

Deep Ache = ZZZZ
Sharp/Stabbing = ////
Pins and needles = 0000
Burning = XXXX
Throbbing = ++++
Cleared = ✓