



### NEW PATIENT PAPERWORK – WORKERS COMPENSATION

PATIENT INFORMATION		
Patient Name:	Preferred:	DOB:
Address, City, State, Zip:		
Email Address:	Social Security #:	

Home Phone:
Cell Phone:
Work Phone:

Appointment Reminder Method		
Home Phone <input type="checkbox"/>	Cell Phone <input type="checkbox"/>	Text <input type="checkbox"/>

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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Partner's Name:
Financial Responsibility: <input type="checkbox"/> Self <input type="checkbox"/> Other
Emergency Contact: <span style="margin-left: 150px;">Phone:</span> <span style="margin-left: 150px;">Relation:</span>

Have you had Physical Therapy treatment since January of this year? <input type="checkbox"/> Yes <input type="checkbox"/> No # of visits:
Have you had Chiropractic treatment since January of this year? <input type="checkbox"/> Yes <input type="checkbox"/> No # of visits:
Have you had Home Healthcare in the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Healthcare Provider:

CONSENT TO TREAT
I hereby authorize and consent to treatment/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 provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternative to the treatment plan that has been recommended.
Patient/Guardian Signature: <span style="float: right;">Date:</span>

AUTHORIZATION
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, pre-certifications, 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 and all services provided.
Patient/Guardian Signature: <span style="float: right;">Date:</span>

Please fill out the Accidental Injury Questionnaire (page 2) for the physical therapy care being the result of an injury related to Workers Compensation.



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If you are filing your claims with your group health plan, it may have a reimbursement provision for claims resulting from an act or omission of a third party. The term “Third Party” can be a person, business, or other entity. In most cases, the third party has insurance to cover your claims. The medical expenses that your group health plan pays, which are also paid by the third-party insurance, may need to be reimbursed to your group health plan.

I hereby authorize any third party or insurer to reimburse my group health plan for benefit payments made on my behalf as a result of this accident involving myself and/or my dependents. The above answers are true to the best of my knowledge. I understand that I am fully responsible for any balance for services rendered. I also understand that if payment is denied by the above-mentioned parties, I will be personally responsible for the full amount charged for all services rendered.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### ACCIDENTAL INJURY QUESTIONNAIRE

Is this physical therapy care the result of a Workers Compensation claim? Yes  No

Date of Accident: \_\_\_\_\_

Location of Accident: \_\_\_\_\_

Attorney’s Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

#### Please provide the following information:

Name of Employer: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Employer’s WC Insurance Carrier: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Worker’s Compensation Claim or Case #: \_\_\_\_\_

Nurse Case Manager Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

#### NOTICE OF PRIVACY PRACTICE

(Patient/Guardian Initials)\_\_\_\_\_ I acknowledge that I have received the practices Notice of Privacy Practice, which describes the ways in which the practice 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 Confluent Health Compliance and Privacy Officers listed 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 practices Notice of Privacy Practice.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For questions, please contact the Compliance Department (Toll free) at 888-937-4479.

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PATIENT HEALTH QUESTIONNAIRE			
Occupation:	Height:	Weight:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Leisure Activities/Hobbies:			
Are you? <input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed			
Where do you live? <input type="checkbox"/> Private home <input type="checkbox"/> Apartment/rented room <input type="checkbox"/> Assisted living/group home <input type="checkbox"/> Hospice <input type="checkbox"/> Other			
With whom do you live? <input type="checkbox"/> Alone <input type="checkbox"/> Spouse only <input type="checkbox"/> Spouse and others <input type="checkbox"/> Child <input type="checkbox"/> Other			
Does your home have? <input type="checkbox"/> Stairs, no railing <input type="checkbox"/> Stairs, railing <input type="checkbox"/> Ramps <input type="checkbox"/> Uneven terrain Please explain:			
How many times have you fallen in the past 12 months?		Did it result in an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? <input type="checkbox"/> Yes <input type="checkbox"/> No			
General Health Status, please rate your health. <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			

Please list any known allergies (including medications, latex, etc.) below:

Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.			
Name	Dosage	Frequency	Please indicate route
			Oral    Patch    Topical    Other
			Oral    Patch    Topical    Other
			Oral    Patch    Topical    Other
			Oral    Patch    Topical    Other
			Oral    Patch    Topical    Other

Surgery / Hospitalization, please include date and reason.	

Are you currently experiencing any of the following?			
Nausea or Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pains (Angina)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Productive/chronic cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain wakes me at night	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent fever, chills, sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing loss/ringing in ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unusual weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue or myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint pain or swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained weight changes	<input type="checkbox"/> Yes <input type="checkbox"/> No

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<b>Have you been diagnosed with any of the following?</b>			
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety or Panic Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Auto Immune Disease If yes, Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metal Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel or Bladder Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer If yes, Site:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peripheral Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Cord Stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema/Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gall Bladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis If yes, Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Social History / Wellness</b>	
Do you drink alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No / Comments:
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No / Comments:
How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? <input type="checkbox"/> At least 3 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Seldom or Never	

<b>Current Condition</b>
When did this problem(s) first begin?
Describe the problem(s).
Explain how problem(s) occurred.
Have you ever had this problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times?
Are your symptoms worse in the: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Same all day

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How are you taking care of the problem(s) now?

My pain/problem is slowing getting:  Worse  Better  Staying the same

My symptoms bother me:  Constantly (100%)  Most of the time (75%)  
 Occasionally (50%)  Once in a while (25%)

Do you have any numbness, tingling, or burning?  Yes  No  
 If yes, please check one:  Constantly  Intermittently

What functions could you perform before, that you now are unable to do?

Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.

Please list the dates and results of any:

X-Rays:

MRI:

Bone Density Test:

Nerve Conduction Test:

Other:

Are you aware of any physical reason why you should not receive treatment?  Yes  No  
 If yes, please tell us what it is:

What are your goals for therapy?

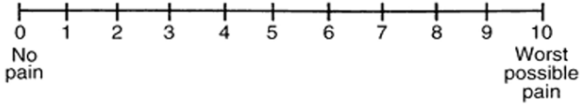
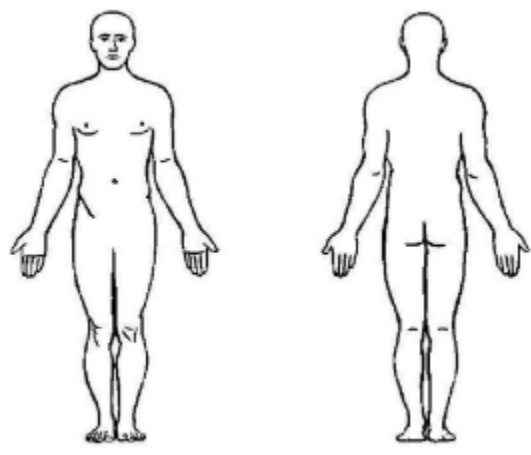
Symptoms Rating

Mark location of symptom(s)

- for pain
- for numbness/tingling/burning

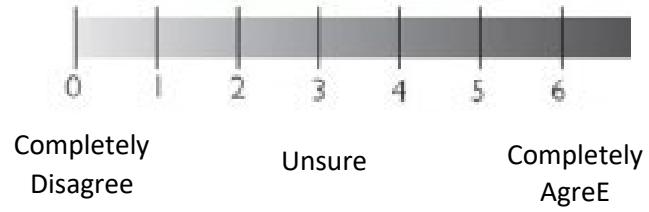
Please rate your pain - on a scale from 0 – 10  
 (0 = No Pain; 10 = Worst pain imaginable)

Current: / 10	Best: / 10	Worst: / 10
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“I should not do physical activity which (might) make my pain worse.”  
Please rate your level of agreement on the scale below:



Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_