PATIENT INFORMATION FORM

820 Stuart Rd NE | Cleveland , TN 37312 | (423) 790-8435 | Fax: (423) 790-7990

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 # ( )	Employer Address			
Policy Holder's Name	Policy Holder's DOB / /	Policy Holder's SSN	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 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 or Visa. We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit same to Advanced PT. The above does not apply for those patients that are considered Workers' Compensation; however, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

Initial _____

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Advanced PT cannot treat patients on a contingency basis; therefore, where legal cases are pending settlement, we require that the full charge be paid at the time of treatment unless prior arrangements have been made and documented.

CONSENT FOR TREATMENT AND AUTHORIZATION

I do hereby consent for treatment at Advanced Physical Therapy. I authorize Advanced PT 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 Advanced Physical Therapy, LLC when indicated on claim. I understand I am financially responsible for the services I received.

Signed:_____ Date:_____

Relationship to Patient (self/parent/guardian) :_____

Witnessed by:_____

ADVANCED PHYSICAL THERAPY

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Patient's Name:_____ **Date of Birth:**_____

CURRENT CONDITION(S)/CHIEF COMPLAINTS

1. Who referred you to Physical Therapy?

_____

2. Please indicate the body part(s) to be treated today.

☐ Neck ☐ Shoulder ☐ Elbow ☐ Wrist/Hand
☐ Back ☐ Hip ☐ Knee ☐ Ankle/Foot
☐ Other:_____
a. ☐ Left ☐ Right

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 ☐ Manual Wheelchair
☐ Motorized Wheelchair
☐ Other:_____

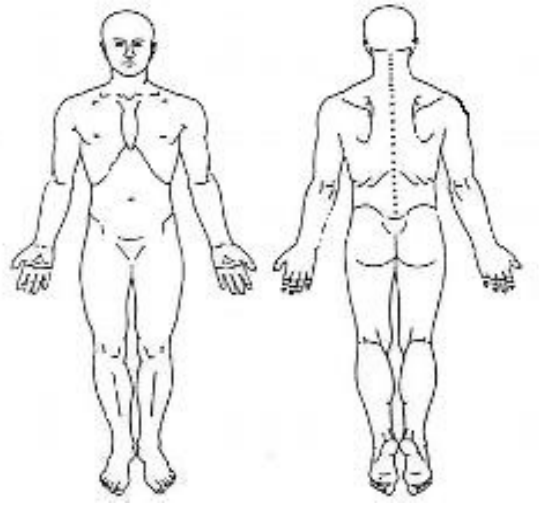
8. Are you seeing anyone else for the problem(s)?

☐ Acupuncturist ☐ Orthopedist
☐ Cardiologist ☐ Osteopath
☐ Chiropractor ☐ Podiatrist
☐ Family Practitioner ☐ Psychologist/Counselor
☐ Internist ☐ Physiatrist
☐ Massage Therapist ☐ Rheumatologist
☐ Neurologist ☐ Other _____
☐ Ob/Gyn

9. Please list the three activities that are most difficult for you because of this current injury:

1. _____
2. _____
3. _____

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



11. Using the pain scale below please chose one number that best answers the following **three questions**:

PAIN SCALE: *(Worst possible pain)*
(No pain) 0 1 2 3 4 5 6 7 8 9 10

a. What is your pain level AT ITS WORST? _____

b. What is your pain level RIGHT NOW?_____

c. What is your pain level AT ITS BEST? _____

Patient/Guardian Signature:_____ Date:_____

Reviewed by:_____ License #:_____ Date_____

MEDICAL/SOCIAL HISTORY FORM

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Patient Name:_____ **Date of Birth**:_____

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. 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
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Low blood sugar
- ☐ Kidney problems
- ☐ 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:_____

For Office Use

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

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

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

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

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

For Office Use

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

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

For Office Use

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? _____

5. 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:_____

Reviewed by:_____ License #:_____ Date: _____

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Advanced Physical Therapy strives to provide the highest quality of care while attempting to accommodate each patient's schedule. Therefore, we provide each patient a reserved time slot with a specific therapist in order to minimize wait time and assure continuity of treatment. Consistent attendance and adherence to the planned treatment regimen is paramount to your care and recovery.

While we are sensitive to the fact that an emergency may occur, cancellations, tardiness, and absentees reduce our ability to accommodate the scheduling needs of our patients. As such, we request your full cooperation with the following company policy:

- For cancellations please call us at least **24 hours** prior to your appointment time.
- There is a **$50.00 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
    - Two consecutive absences without advanced notification may result in the cancellation of all your remaining appointments.
    - Repeated failure to comply with this policy will result in your appointments being scheduled based on availability, which will require you to call for an appointment of the day you would like to receive therapy.

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 Advanced PT 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 Advanced 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:_____