



## 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 # ( )	Employer Address			
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, Master Card, Visa, Discover, American Express .

#### Insurance Filing

Pace 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 Pace 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 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 Pace 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: \_\_\_\_\_

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

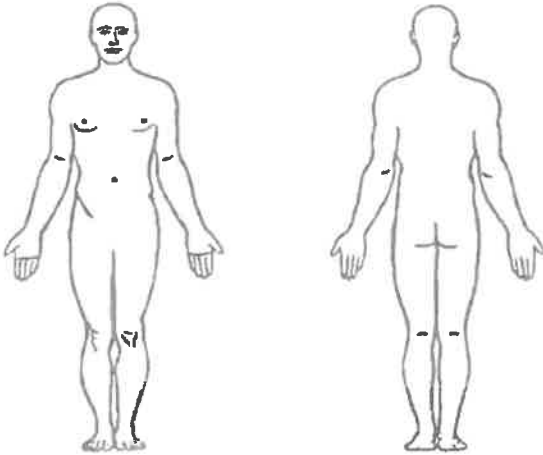
Date of Birth: \_\_\_\_\_

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

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:

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

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

- |  |   |
|--|---|
| <input type="checkbox"/> Bowel/bladder problems    | <input type="checkbox"/> Loss of appetite             |
| <input type="checkbox"/> Chest pain                | <input type="checkbox"/> Loss of balance              |
| <input type="checkbox"/> Coordination problems     | <input type="checkbox"/> Nausea/vomiting              |
| <input type="checkbox"/> Difficulty swallowing     | <input type="checkbox"/> Pain at night                |
| <input type="checkbox"/> Dizziness/Lightheadedness | <input type="checkbox"/> Shortness of breath          |
| <input type="checkbox"/> Fatigue                   | <input type="checkbox"/> Unexplained weakness         |
| <input type="checkbox"/> Fever/chills/sweats       | <input type="checkbox"/> 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.)

- |  |  |
|--|--|
| <input type="checkbox"/> Angiogram               | <input type="checkbox"/> Mammogram               |
| <input type="checkbox"/> Biopsy                  | <input type="checkbox"/> MRI                     |
| <input type="checkbox"/> Bone Density Scan       | <input type="checkbox"/> Myelogram               |
| <input type="checkbox"/> CT Scan                 | <input type="checkbox"/> Nerve Conduction Test   |
| <input type="checkbox"/> Doppler Ultrasound      | <input type="checkbox"/> Pulmonary Function Test |
| <input type="checkbox"/> Echocardiogram          | <input type="checkbox"/> Stress Test             |
| <input type="checkbox"/> EKG (electrocardiogram) | <input type="checkbox"/> X-rays                  |
| <input type="checkbox"/> EMG (electromyogram)    | <input type="checkbox"/> Other: _____            |

### 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

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ BP: \_\_\_\_\_ HR: \_\_\_\_\_ FALLS?  YES  NO \_\_\_\_\_

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

6. In 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 \_\_\_\_\_

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

Physical Therapist Signature: \_\_\_\_\_ License #: \_\_\_\_\_ Date: \_\_\_\_\_



**Current Prescription Medications**

Name	Dosage	Fequency	Route of Adminstration	Reason for Taking
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	

**Current over the Counter ( Non-Prescription) Medications**

Name	Dosage	Fequency	Route of Adminstration	Reason for Taking
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	

**Current Vitamins and Supplements**

Name	Dosage	Fequency	Route of Adminstration	Reason for Taking
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	
			<input type="radio"/> Oral <input type="radio"/> Topical <input type="radio"/> Other	

for office use