Patient Information

PT:____OT:____ST:____

Date:_____

Last Name:_____First Name:_____M.I.:_____

DOB:_____/_____/_____ SS#_____-_____-_____ Male:_____Female:_____

Home Address:_____City:_____Sate:_____Zip:_____

Home/Cell Phone:_____Email Address:_____

Work Status: FT:_____PT:_____RETIRED:_____MINOR:_____SELF EMPLOYED:_____UNEMPLOYED:_____

EMPLOYER

Employer Name:_____

Address:_____

Employer Phone:_____Occupation:_____

NEXT OF KIN

Name:_____Phone Number:_____Relation:_____

Address:_____

PERSON TO NOTIFY

Name:_____Phone Number:_____Relation:_____

Address:_____

HEALTHCARE PROVIDER

Primary Care Physician:_____Office Number:_____Fax:_____

Referring Physician:_____Office Number:_____Fax:_____

INSURANCE

Primary Insurance Provider:_____Phone Number:_____

Member ID:_____Group Number:_____

Secondary Insurance Provider:_____Phone Number:_____

Member ID:_____Group Number:_____

Patient Clinical History/Summary Form

Symptoms began on: (date)_____

Briefly describe your symptoms:_____

_____

_____

How did your symptoms start?:_____

_____

_____

Average Pain Intensity

Last 24 hours: No pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain
Past week: No pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain

What makes it worse:_____

_____

What makes it better:_____

_____

How often do you experience your symptoms?

(1) Constantly (76-100% of the time) (2) Frequently (51-75%) (3) Occasionally (26-50% of the time)

(4) Intermittently (0-25%)

How much have your symptoms interfered with your usual daily activities?

(1) Not at all (2) A little bit (3) moderately (4) Quite a bit (5)Extremely

In general, how would you say your overall health is right now?

(1) Excellent (2) Very Good (3) Good (4) Fair (5) Poor

Please list any other prior injuries/surgeries. Include dates (if possible):_____

_____

_____

Have you had any treatment for this problem?:_____

Circle all tests performed for your PRESENT problem (include dates if possible)

CT scan:_____MRI:_____X-Ray:_____Bone Scan:_____EMG/NCV:_____

List of current medications (prescribed or over the counter):_____

_____

List any allergies:_____

_____

Have you **EVER** been diagnosed as having, or do you have any of the following conditions? (check all that apply)

- ○ AIDS
- ○ ANEMIA
- ○ ANXIETY
- ○ ARTHRITIS
- ○ ASTHMA
- ○ CANCER
- ○ CIRCULATORY PROBLEMS
- ○ COPD
- ○ CVA/STROKE
- ○ DEPRESSION
- ○ DIABETES
- ○ DIZZINESS
- ○ EATING DISORDER
- ○ EPILEPSY
- ○ HEADACHES
- ○ HEARING LOSS
- ○ HEART ABNORMALITY
- ○ HEART ATTACK
- ○ HEART DISEASE
- ○ HEPATITIS
- ○ HIGH/LOW BLOOD PRESSURE
- ○ JOINT REPLACEMENT
- ○ KIDNEY DISEASE
- ○ METAL IMPLANTS
- ○ MULTIPLE SCLEROSIS
- ○ NERVOUS DISORDER
- ○ OSTEOPOROSIS/OSTEOPENIA
- ○ PACEMAKER
- ○ PARKINSON'S
- ○ PREGNANT
- ○ POST-POLIO
- ○ PROSTATE PROBLEMS
- ○ RHEUMATOID ARTHRITIS
- ○ SEIZURE DISORDER
- ○ THYROID PROBLEM
- ○ TUBERCULOSIS
- ○ URINARY INCONTINENCE
- ○ VERTIGO
- ○ OTHER:

What are your expectations of therapy?:_____

_____

Patient informed consent obtained: discusses with patient/family diagnosis, goals, plan of care, possible risks, anticipated outcome(s), and other alternatives to therapy

Patient or Guardian Signature:_____Date:_____

Acknowledgment of Receipt of Notice of Privacy Practice and Patient Information

As required by the Privacy Regulations, I hereby acknowledge that I have been presented a copy of this practice's "HIPPA Notice of Privacy Practices" and Patient Information and Responsibilities.

As required by the Privacy Regulator, I am aware that this practice has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

I understand that this office may change their Notice of Privacy Practices and is not required to honor the terms of the original/previous version(s).

- o I wish to file a "Request for Restriction" of my Protected Health Information.
- o I wish to file a "Request for Alternative Communications" of my Protected Health Information.
- o I wish to object to the following in the "Notice of Privacy Practices."

_____

_____

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected healthcare information for the purpose of treatment, payment, and healthcare operations as described in the Privacy Notice.

Patients Name(print):_____

Patient Signature:_____Date:_____

Therapist Signature:_____Date:_____

Patient Information and HIPPA Notice of Privacy Practices

Thank you for preferring Premier Physical Therapy for your rehabilitation treatment. We appreciate your confidence in our services.

Our mission is to provide high quality and comprehensive professional care to educate and empower the patients towards achieving overall physical health, fitness and quality of life.

Non-Discriminatory:

At Premier Physical Therapy we treat our patient regardless of religious belief, legal status, political opinion, age, race, color, cultural background, national origin, gender, sexual orientation, physical or mental disability or handicap.

Insurance:

It is your responsibility to ensure we have the latest Health Insurance information on file. If a new card is issued during your treatment, you must bring it into the office ASAP. You should be aware of terms and conditions of your policy. ie limits, deductible changes etc. Copay and Coinsurance are due at the time of your visit. Any over-payments will be refunded in less than 30 days from the final Explanation of Benefits.

Any services by insurance will be due to Premier Physical Therapy 30 days from Statement date. Including lapse of coverage or policy changes

CareCredit Payment plans are available.

X_____Date:_____

Please see the office copy of the HIPPA Notice of Privacy Practices.

A personal copy can be made for you upon request.

Photography/Video Permission Form

As part of our rehab/therapy activities, Premier Physical Therapy (PPT) occasionally uses photographs or video of our patients. Any image(s) that we obtain of you/your relative will remain in the property of Premier Physical Therapy and will be used for the promotion/advertisement purposes of Premier Physical Therapy.

All personal contact details will remain strictly confidential.

I hereby grant permission to Premier Physical Therapy, PLLC to utilize my image(s) in any and all manner and media throughout the world in perpetuity.

I agree that my image(s) may be edited at the sole discretion of Premier Physical Therapy, PLLC. I consent to the use of my name, likeness, voice for the use of publicity and institutional promotional purposes. I expressly release Premier Physical Therapy, PLLC and its agents, employees, licensees and assigns from and against any and all claims which I have or may have for any kind of monetary reimbursement(s), invasion of privacy, defamation, or any other cause of action arising out of production, distribution, broadcast or exhibition of the promotion and/or advertisement.

If for any reason you *DO NOT* consent to any of the above, *DO NOT SIGN BELOW!!!!*

- **(Must be signed by parent/guardian if patient is under 16 years of age)**

Name:_____Date of Birth:_____

Name of parent/guardian:_____

Contact Number:_____

Signature:_____Date:_____