Patient Demographics

PATIENT INFORMATION

Patient's Name (Last, First, Middle Initial):

Patient's Address:

Phone #:
Home:
Cell:
Work:

City:

State:

Zip Code:

Patient Date of Birth (MM/DD/YYYY):

Age:

Sex:
☐ Male ☐ Female

Patient Relationship to Insured:
☐ Self ☐ Spouse ☐ Child ☐ Other

Email Address:

Consent to email:
☐ Yes ☐ No

Patient Marital Status:
☐ Single ☐ Married ☐ Other

Employer / Occupation:

Living Environment / Do you have help at home?

Emergency Contact Person / Phone #:

Relationship to Patient:

Responsible Party information (if different than above):

INSURANCE INFO

Insured's Name (Last, First, Middle Initial) :

Insured's DOB (MM/DD/YYYY) :

Relationship to Patient:
☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

Name of PRIMARY Insurance Company:

Member ID:

Group #:

Name of SECONDARY Insurance Company:

Member ID:

Group #:

M.D. INFO

Referring Physician Name / Address:

Primary Physician Name / Address:

Secondary Referral Source:
☐ Previous Patient ☐ Referred by MD/Office
☐ Advertisement ☐ YMCA staff
☐ Community Event ☐ Home care staff
☐ Other:

Please print name and date at bottom of each page:

Name: _____ DOB: _____

Reason for Visit

REASON FOR VISIT

What is the reason for today's visit?

When did this problem happen?

Which side:

☐ Left ☐ Right ☐ Both sides

Hand dominance?

☐ Left ☐ Right ☐ Ambidextrous

How did this problem happen?

What makes it better?

What makes it worse?

Associated symptoms and pain description (check all that apply):

☐ Clicking ☐ Swelling ☐ Locking ☐ Buckling ☐ Stiffness ☐ Weakness ☐ Difficulty walking ☐ Difficulty with stairs

☐ Constant ☐ Intermittent ☐ Sharp ☐ Burning ☐ Deep Ache ☐ Stabbing pain ☐ Radiating (to where?):

☐ Numbness / Tingling / Pins and Needles ☐ Decreased balance / stability ☐ Falls

☐ Other (please explain):

Does the pain wake you up at night? ☐ No ☐ Every night ☐ Occasionally ☐ Rarely

What are your goals?

When do you expect it to get better?

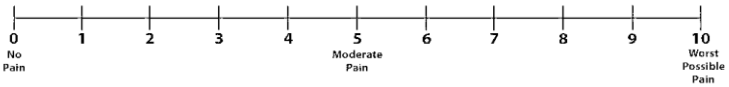
On a scale of 0 to 10:

Please rate your *current* level of pain:

Please rate your *worse* level of pain in the last 24 hours:

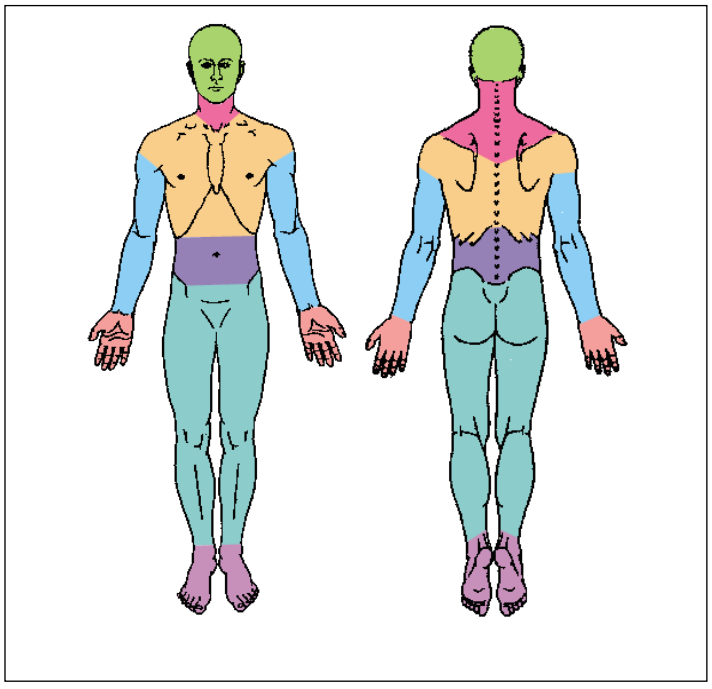
Please rate your *best* level of pain in the last 24 hours:

Numeric Rating Scale



Wong-Baker FACES® Pain Rating Scale

Indicate below where your symptoms are:



Name: _____ DOB: _____

General Health Screening Questionnaire

In order for us to provide a thorough evaluation, please answer the following questions regarding your medical history. Your therapist will assist you if you have any difficulty. Please check any of the following conditions that you may have:

Cancer	**N**	**Y**	Heart Condition	**N**	**Y**
			Do you have a pacemaker?	**N**	**Y**
Asthma	**N**	**Y**	High Blood Pressure	**N**	**Y**
Emphysema or Bronchitis	**N**	**Y**	Circulation / Vascular Problem	**N**	**Y**
Tuberculosis	**N**	**Y**	Stroke	**N**	**Y**
Low Blood Sugar	**N**	**Y**	Osteoarthritis	**N**	**Y**
Diabetes	**N**	**Y**	Osteoporosis	**N**	**Y**
Thyroid condition	**N**	**Y**	Rheumatoid Arthritis	**N**	**Y**
Hepatitis	**N**	**Y**	Fractured / Broken Bones	**N**	**Y**
			Other Arthritic Condition	**N**	**Y**
Multiple Sclerosis	**N**	**Y**			
Other Neurological Condition	**N**	**Y**	Depression	**N**	**Y**
			Mental Illness	**N**	**Y**
Skin Conditions	**N**	**Y**	Epilepsy or Seizure	**N**	**Y**
			Chemical Dependency / Alcoholism	**N**	**Y**
Ulcers or Stomach Problems	**N**	**Y**			
			Kidney Disease	**N**	**Y**
Prostate problems	**N**	**Y**	Anemia	**N**	**Y**
Endometriosis / other OBGYN problems	**N**	**Y**			
Complicated Pregnancy / Delivery	**N**	**Y**			
Other (please explain):					
Comments / Additional Information:					

Please describe any **surgeries** or **hospitalizations** (and approximate years) that you have ever had:

Please list **any injuries** that you may have had **which required medical attention** (when and how long?):

Please list any **prescription medications** you are taking:

Pain:	Cholesterol:	Thyroid:	Psychological:
Blood Pressure:	Diabetes:	Nerve:	Other:

Check any **nonprescription medications** that you are currently taking:

□ Aspirin	□ Antihistamines	□ Laxatives
□ Tylenol	□ Decongestants	□ Vitamins
□ Advil / Motrin / Ibuprophen	□ Antacids	□ Supplements

Name: _____ DOB: _____

Within the past year, have you had any of the following tests? Check all that apply:

Angiogram	**N**	**Y**	Echocardiogram	**N**	**Y**
Biopsy	**N**	**Y**	Mammogram	**N**	**Y**
Blood test	**N**	**Y**	MRI	**N**	**Y**
Bone Scan	**N**	**Y**	Stress Test	**N**	**Y**
CT scan	**N**	**Y**	Urine Test	**N**	**Y**
Doppler Ultrasound	**N**	**Y**	X Rays	**N**	**Y**
			Other:		

Has anyone in your immediate family (parents / siblings) ever been diagnosed with the following:

Cancer	**N**	**Y**	Alcoholism / Chemical dependency	**N**	**Y**
High Blood Pressure	**N**	**Y**	Diabetes	**N**	**Y**
Heart Condition	**N**	**Y**	Kidney Disease	**N**	**Y**
Mental Illness	**N**	**Y**	Stroke	**N**	**Y**
Arthritis / Osteoporosis	**N**	**Y**	Other:		

Have you recently (6 months) noted any new or changes in the following:

Body weight	**N**	**Y**	Bowel / Bladder issues	**N**	**Y**
Dizziness	**N**	**Y**	Vision / Hearing	**N**	**Y**
Headaches	**N**	**Y**	Coughing	**N**	**Y**
Weakness / Fatigue	**N**	**Y**	Numbness / Tingling	**N**	**Y**
Fever / Chills / Sweats	**N**	**Y**	Other:		

Have the following healthcare providers provided you care in the past 3-6 months or are currently providing you care:

Medical Doctor	**N**	**Y**	Acupuncturist	**N**	**Y**
Chiropractor	**N**	**Y**	Massage Therapist	**N**	**Y**
Dentist	**N**	**Y**	Homeopath	**N**	**Y**
Psychiatrist / Psychologist	**N**	**Y**	Physical Therapist	**N**	**Y**
			Other:		

Are you, or do you think that you may be pregnant?	**N**	**Y**
Do you have religious beliefs that might affect your care?	**N**	**Y**
If you were to lose consciousness under our care, would you want lifesaving measures (CPR) to be performed to save or resuscitate you?	**N**	**Y**
Are you allergic or sensitive to latex?	**N**	**Y**
Are you allergic to shellfish or iodine?	**N**	**Y**

How may coffee / beverages with caffeine do you think you drink per day?	Cups
How many packs of cigarettes do you smoke a day?	Packs
How many glasses of wine or beer do you consume in an average sitting?	Glasses
How many days per week do you use illicit drugs?	

During the past month have you been feeling depressed, down or hopeless?	**N**	**Y**
During the past month have you had little interest or pleasure in doing things?	**N**	**Y**
Do you ever feel unsafe at home or has anyone ever hit or tried to injure you in any way?	**N**	**Y**

Name: _____ DOB: _____

Questions related to the **Graston Technique** and **Dry Needling**:

Do you bruise easily?	**N**	**Y**
Do you bleed for a long time after you get cut?	**N**	**Y**
Are you taking blood thinners or anticoagulants?	**N**	**Y**
Do you take aspirin on a regular basis?	**N**	**Y**
Do you take cortisone on a regular basis?	**N**	**Y**
Have you ever had inflamed veins or blood clots?	**N**	**Y**
Do you have any surgical implants?	**N**	**Y**
Do you have uncontrolled blood pressure?	**N**	**Y**
Do you currently have any infections?	**N**	**Y**
Are you allergic to bees wax?	**N**	**Y**
I have a fear of needles.	**N**	**Y**
I have a genetic bleeding disorder. Please specify:	**N**	**Y**
I have a history of a blood disorder that can be transmitted to another person. Please specify:	**N**	**Y**
I am regularly taking pain relievers. Please specify:	**N**	**Y**

Notes:

Name: _____ DOB: _____

Consent To Treatment & Financial Policies

For patients with private insurance: I understand that payment for service is due at the time of service. I am responsible for seeking my own reimbursement from my insurance company, flexible spending account or health savings account. I am responsible for understanding the limits and requirements of my insurance policy including need for referrals, prescriptions, deductible and copayments. I agree that Professional Physical Therapy & Training, LLC may discuss my case with my physician or other practitioner for the purpose of my care only. It is my right as a patient to understand the treatment, which I am participating in and can refuse participation at any time. By initialing and signing this form, I consent to physical therapy treatment.

For patients with Medicare insurance: I request that payment of authorized benefits be paid on my behalf to Professional Physical Therapy & Training, LLC for services furnished to me by the Professional Physical Therapy& Training, LLC. I authorize any holder with medical information about me to release to Medicare or other insurance any information needed to determine these benefits payable for related services. I understand that Professional Physical Therapy & Training, LLC accepts assignment of Medicare, which pays 80% of the allowable charges for service. I will be responsible for the remaining 20 percent. I agree that Professional Physical Therapy & Training, LLC may discuss my case with my physician or other practitioner for the purpose of my care only. It is my right as a patient to understand the treatment, which I am participating in and can refuse participation at any time. By initialing and signing this form, I consent to physical therapy treatment.

Initial _____

Cancellation Policy

Professional Physical Therapy and Training strives to provide its patients with exceptional care. All our sessions are one hour in length. Our therapists spend that time one-on-one with each client. Not attending your appointment inhibits our ability to help you achieve your goals and adversely affects our ability to function financially.
By initialing you understand that you MAY be charged half of the visit fee for cancellations without twenty-four hours notice, or you WILL be charged the entire visit fee for an appointment no show.

Initial _____

Graston Technique Informed Consent

All components of the Graston Technique have been explained to me. I understand the risks of the procedure and give my full consent for treatment.

Initial _____

Dry Needling Consent to Treat

I have read the patient information and consent to having the procedure performed on me. I understand that this procedure is *not acupuncture.*

Initial _____

By signing below I hereby consent to the above and allow Professional Physical Therapy and Training, LLC to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Print Name: _____

Signature: _____ **Date:** _____

If patient is less than 18 years of age parent or legal guardian must sign:

Signature of parent / legal guardian: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____

Name: _____ DOB: _____

Oswestry Disability Questionnaire (LOWER BACK)

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box, which most closely describes your current condition**.

Pain Intensity

- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad but I can manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me with moderate relief from pain.
- ☐ Pain medication provides me with little relief from pain.
- ☐ Pain medication has no affect on my pain.

Personal Care (Washing, Dressing etc.)

- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Lifting

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (ex. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I can not lift or carry anything at all.

Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk with crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Standing

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but increases my pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than ½ hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Evens when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

Social Life

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex. sports, dancing etc.)
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Traveling

- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ My pain restricts travel over 2 hours.
- ☐ My pain restricts my travel over 1 hour.
- ☐ My pain restricts my travel to short necessary journeys under ½ hour.
- ☐ My pain prevents all travel except for visits to the doctor/therapist or hospital.

Employment/Homemaking

- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pan prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

[For office use]

Score:_____%
Score = Sum or responses ÷Number possible x 100

Name: _____ DOB: _____