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 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?

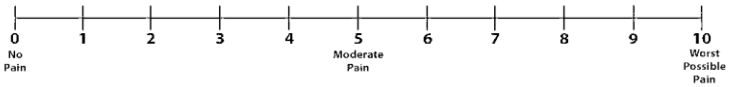
On a scale of 0 to 10:

Please rate your *current* level of pain:

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

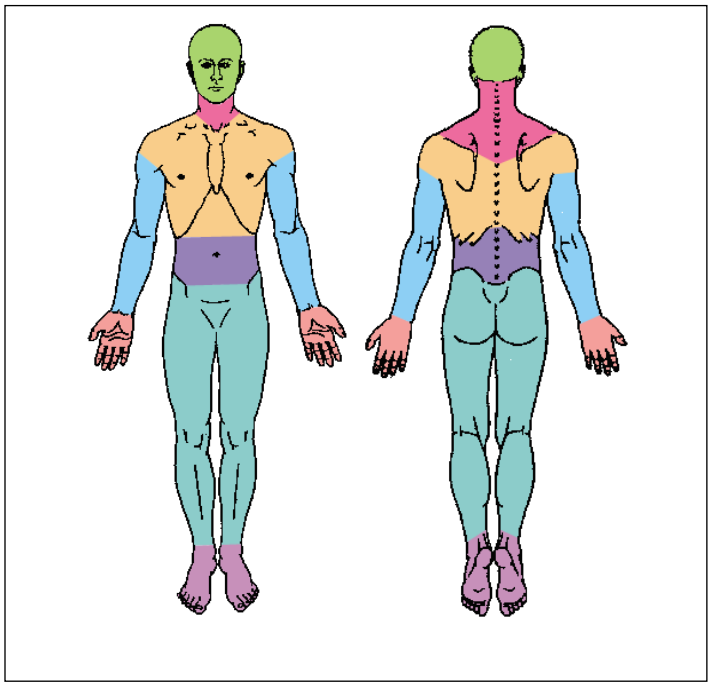
Please rate your *best* level of pain in the last 24 hours:

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: _____

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____ / 80

Please submit the sum of responses.

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

DOB: _____

Name: _____