PATIENT INFORMATION

PATIENT NAME (first & last): ______________________________

DATE OF BIRTH: ____________________ **SSN:** ____________________

HOME ADDRESS: ______________________________
STREET CITY STATE ZIPCODE

MAILING ADDRESS (skip if same as above): ______________________________

HOME PHONE NUMBER: ____________________ **CELL PHONE NUMBER:** ____________________

EMAIL ADDRESS: ______________________________

PLEASE SELECT: MARRIED_____ SINGLE _____ STUDENT: _____ OTHER: _______

DO YOU WANT APPOINTMENT REMINDERS? IF YES, SELECT ONE - **TEXT**____ **CALL**____ **EMAIL**____

EMERGENCY CONTACT NAME: ____________________ **PHONE:** ____________________

RELATIONSHIP TO PATIENT: ____________________

DO YOU HAVE INSURANCE? **YES**_____ **NO** _____

PRIMARY INSURANCE NAME: ______________________________

SECONDARY INSURANCE NAME: ______________________________

FINANCIAL RESPONSIBILITY FOR THIS ACCOUNT: (skip if same as above)

NAME (first & last): ____________________ **DATE OF BIRTH:** ____________________

MAILING ADDRESS: ______________________________

PHONE NUMBER: ____________________ **SSN:** ____________________

WORKER'S COMPENSATION? **YES**_____ **NO** _____ DATE OF INJURY: ____________________

EMPLOYER NAME & NUMBER: ____________________ CLAIM NUMBER: ____________________
ADJUSTER NAME & NUMBER: ______________________________

MOTOR VEHICLE ACCIDENT? **YES** _____ **NO** _____ DATE OF INJURY/ACCIDENT: ____________________

AT FAULT _____ NOT AT FAULT _____ CLAIM NUMBER: ____________________
INSURANCE COMPANY NAME & ADDRESS: ______________________________
ADJUSTER NAME & NUMBER: ______________________________

______________________________ ____________________
Patient or Parent/Legal Guardian Signature **Date**

FAMILY Physical Therapy & SPORTS CENTER

PERSONAL INFORMATION

NAME: ______________________________ DOB: _________________

Describe the current problem that brought you here: ______________________________________

____

When did your problem first begin? _______ months ago _______ years ago

Was your first episode of the problem related to a specific incident? _____ YES _____ NO

If yes please describe: ____

Since that time the problem is: ______ the same _____ getting worse _____ getting better

What relieves your symptoms? ____

CURRENT Pain Level: _______ ***BEST*** Pain Level: _______ ***WORST*** Pain Level: _______

0 No pain | 1 | 2 | 3 | 4 | 5 Moderate pain | 6 | 7 | 8 | 9 | 10 Worst possible pain

MARK AREAS OF DISCOMFORT:

FRONT BACK

TYPE OF PAIN (check all that apply)

- ☐ ACHING
- ☐ BURNING
- ☐ CONSTANT
- ☐ DULL
- ☐ NUMBNESS
- ☐ SHARP
- ☐ STABBING

Activities / events that cause or aggravate your symptoms: (check all that apply)

- ☐ Changing positions (sit to stand)
- ☐ Cold weather
- ☐ Coughing / sneezing / straining
- ☐ Laughing / yelling
- ☐ Lifting / bending over
- ☐ Light activity
- ☐ No activity affects the problem
- ☐ Sexual activity
- ☐ Sitting more than ____ minutes
- ☐ Standing more than _____ minutes
- ☐ Triggers (running water/keys in door)
- ☐ Vigorous activity
- ☐ Walking more than ____ minutes
- ☐ With nervousness/anxiety
- ☐ Other: ______________________________

FAMILY Physical Therapy & SPORTS CENTER

PERSONAL INFORMATION

Since onset of your current symptoms have you had:

Y / N Change in bowel/bladder functions
Y / N Dizziness / fainting
Y / N Fever / Chills
Y / N Malaise (unexplained tiredness)
Y / N Night pain / sweats
Y / N Numbness or tingling
Y / N Unexplained muscle weakness
Y / N Unexplained weight change
Other: ____________________

Describe how your lifestyle/quality of life has been altered/changed because of this problem:

Social activity: ____________________
Diet / fluid intake: ____________________
Physical activity: ____________________
Work: ____________________
Other: ____________________

Rate the severity of the problem from 0–10 with 0 being no problem and 10 being the worst: ________

What are your treatment goals? ____________________

Date of last physical exam: ____________________
Tests performed during exam: ____________________

General health (circle one): EXCELLENT GOOD AVERAGE FAIR POOR

Occupation: ____________________ Hours/week: ________ On disability or leave? ________

Current level of stress (circle one): HIGH MODERATE LOW

Activity/Exercise (circle one): None 1-2 days/week 3-4 days/week 5+ days/week

Medications/Vitamins: ____________________
____
____

Surgical History:

Y / N Abdominal organs
Y / N Bladder surgery
Y / N Bone / Joint surgery
Y / N Back / Spine surgery
Y / N Brain surgery
Y / N Female organs
Other / describe: ____________________
____

FAMILY Physical Therapy & SPORTS CENTER

CHECK ALL THAT APPLY TO CURRENT OR PAST MEDICAL HISTORY:

- ☐ ALCOHOLISM / DRUG PROBLEM
- ☐ ALLERGIES (FOOD / SEASONAL)
- ☐ ANOREXIA / BULIMIA
- ☐ ASTHMA / BRONCHITIS
- ☐ ARTHRITIS
- ☐ BACK PAIN
- ☐ BALANCE / HISTORY OF FALLS
- ☐ BLOOD CLOT
- ☐ BOWEL / BLADDER DIFFICULTY
- ☐ BRUISE / BLEED EASILY
- ☐ CANCER / CHEMOTHERAPY
- ☐ CONSTIPATION
- ☐ COPD
- ☐ DEPRESSION
- ☐ DIABETES
  - TYPE: __________
- ☐ DIZZINESS / FAINTING
- ☐ EPILEPSY / SEIZURES
- ☐ FATIGUE
- ☐ FIBROMYALGIA
- ☐ FOOT/ANKLE PAIN
- ☐ HAND/ELBOW PAIN
- ☐ HEADACHES / MIGRAINES
- ☐ HEART ATTACK
- ☐ HEART DISEASE
  - TYPE: __________ ______________
- ☐ HEPATITIS / HIV / AIDS
- ☐ HIGH BLOOD PRESSURE
- ☐ HERNIA
- ☐ IRRITABLE BOWL SYNDROME
- ☐ INCONTINENCE
- ☐ INFECTIOUS DISEASE
- ☐ JOINT REPLACEMENT
  - TYPE: __________ ______________
- ☐ KIDNEY DISEASE
- ☐ KNEE PAIN
- ☐ LATEX ALLERGY / SENSITIVITY
- ☐ LOW BACK PAIN
- ☐ LOW BLOOD PRESSURE
- ☐ MULTIPLE SCLEROSIS
- ☐ NAUSEA
- ☐ NECK PAIN
- ☐ NUMBNESS / TINGLING
- ☐ OSTEOPOROSIS
- ☐ PARKINSON'S DISEASE
- ☐ PELVIC PAIN
- ☐ PHYSICAL / SEXUAL ABUSE
- ☐ SACROILIAC / TAILBONE PAIN
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ SHORTNESS OF BREATH
- ☐ SHOULDER PAIN
- ☐ SLEEPING DIFFICULTY
- ☐ SMOKING HISTORY
- ☐ SPEECH DIFFICULTY
- ☐ STROKE
- ☐ SWALLOWING DIFFICULTY
- ☐ SWELLING OF LIMBS
- ☐ THYROID DISEASE
- ☐ VISION / HEARING DIFFICULTY
- ☐ WEAKNESS
- ☐ WEIGHT LOSS
- ☐ OTHER: ____________________ ____________________ ____________________

OB/GYN History:

Y / N C-Sections # ______

Y / N Difficult childbirths # ______

Y / N Episiotomy # ______

Y / N Menopause – when? ___________

Y / N Painful vaginal penetration

Y / N Painful periods

Y / N Pelvic pain

Y / N Prolapse or organ falling out

Y / N Vaginal deliveries # ______

Y / N Vaginal dryness

NOTICE OF INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Family Physical Therapy and Sports Center, P.C. is required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information. This notice fulfills the "Notice" requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at Family Physical Therapy and Sports Center, P.C., please call us at 308-236-5884 or 308-698-2820.

Acknowledgement of receipt of this notice: I have been informed of the Privacy Policies of Family Physical Therapy and Sports Center, P.C

______________________________ ______________________________

Patient or Parent/Legal Guardian Signature **Date**

RELEASE OF PERSONAL HEALTH INFORMATION:

IF YOU WISH FOR ANYONE OTHER THAN YOURSELF TO HAVE ACCESS TO YOUR MEDICAL OR FINANCIAL RECORDS, PLEASE LIST THOSE NAMES AND THEIR RELATIONSHIP TO YOU BELOW:

RELEASE TO: ______________________________ RELATIONSHIP: ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

AUTHORIZATION FOR RELEASE OF INFORMATION AND CONSENT TO TREAT

The undersigned hereby authorizes ***FAMILY PHYSICAL THERAPY AND SPORTS CENTER*** to furnish from my medical record requested information or excerpts to the referring physicians, if any, and to Medicare, Medicaid, or any insurance company for the purpose of processing claims and to obtain payment of the account for services provided to the patient. By signing, this authorization the patient, parent or legal guardian of the patient hereby gives to medical treatment.

MEDICARE RELEASE

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any authorized benefits be made on my behalf.

FINANCIAL AGREEMENT

The undersigned hereby agrees that, in consideration of the services to be rendered to the patient, to pay ***FAMILY PHYSICAL THERAPY AND SPORTS CENTER*** in accordance with the regular rate and the offices payment policy. Some insurance companies do not pay for hot/cold packs. These are billable services and due by the patient. **A LATE FEE WILL BE CHARGED TO ALL OVERDUE ACCOUNT BALANCES AFTER 60 DAYS.**

WORKER'S COMPENSATION

PLEASE NOTIFY OFFICE STAFF AT CHECK-IN IF THIS IS A WORKER'S COMPENSATION INJURY

Any patient claiming worker's compensation must bring notice of injury from their employer before it will be turned into worker's compensation insurance. Otherwise, all billing will be submitted to personal medical insurance.

ATTENDANCE POLICY

If you are more than 15 minutes late for your appointment and fail to notify us, treatment may be cancelled. Please give 24 HOUR notice if you need to cancel your appointment. **Three consecutive no-shows** will result in the cancellation of all remaining scheduled appointments. Repeated failure to comply with this **ATTENDANCE POLICY** will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

This undersigned certifies that he/she has read the forgoing, and is the patient or duly authorized by or on behalf of the patient to execute the above and accepts its terms.

____ __________________________

Patient or Parent/Legal Guardian Signature **Date**