aprs PHYSICAL THERAPY

PATIENT INFORMATION

PATIENT (LEGAL) NAME:_____ SEX:_____ BIRTHDATE:_____

PREVIOUS/MAIDEN NAME(s): _____ SSN:_____ PHONE:_____

PHYSICAL ADDRESS:_____
City State Zip

MAILING ADDRESS:_____ CELL:_____

EMPLOYER:_____ PHONE:_____

SPOUSE NAME:_____ SPOUSE DOB:_____ PHONE:_____

SPOUSE EMPLOYER:_____ SPOUSE WORK PHONE:_____

EMERGENCY CONTACT (OUTSIDE OF HOME):_____ PHONE:_____

EMAIL ADDRESS (FOR APPOINTMENT REMINDERS):_____

HOW DID YOU HEAR ABOUT US?_____

AUTO INSURANCE INFORMATION

POLICYHOLDER NAME:_____ INSURANCE COMPANY:_____

ADDRESS:_____ PHONE:_____

CLAIMS ADJUSTER:_____ PHONE:_____

CLAIM NUMBER:_____ STATE OF ACCIDENT:_____ ACCIDENT DATE:_____

ATTORNEY:_____ PHONE:_____

SHOULD THE AUTO INSURANCE DENY LIABILITY FOR THE CHARGES, WE CAN BILL YOUR PRIVATE INSURANCE

(**Please note**: *Please provide your private insurance information and/or a copy of your Insurance Card.)*

POLICYHOLDER NAME:_____ DOB:_____ RELATION:_____

INSURANCE COMPANY:_____ ID/CLAIM #:_____ GROUP #:_____

IF UNDER 18 OR A COVERED DEPENDENT

MOTHER'S INFORMATION:

NAME: _____ DOB:_____ PHONE:_____

ADDRESS:_____ EMPLOYER:_____ WORK PHONE:_____

FATHER'S INFORMATION:

NAME: _____ DOB:_____ PHONE:_____

ADDRESS:_____ EMPLOYER:_____ WORK PHONE:_____

PLEASE READ -- IMPORTANT INFORMATION

1. I consent to examination, treatment and procedures that may be performed during office visits considered necessary by the physical therapist.
2. I authorize **Advanced Performance and Rehabilitation Services, Inc.** to request information from my attending physician, attorney, and/or insurer if needed.
3. I authorize the release of medical information to my Insurance Company and to such other persons/organizations as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA).
4. I authorize and request that any insurance benefits be paid directly to **Advanced Performance and Rehabilitation Services, Inc.**
5. I understand that should the Auto Insurance deny liability for these charges, I am financially responsible.
6. I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs, will be added to the balance of my account.
7. Per HIPAA regulations, I acknowledge that this office has a posted Notice of Privacy Practice available in the patient reception area. A copy is available by request. We will not use or disclose your health information without your authorization, except as described in this notice.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY (PATIENT OR PARENT/GUARANTOR IF PATIENT IS A MINOR) DATE

MEDICAL INFORMATION

NAME: _____ DATE: _____

A. PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS:

1. ARE YOU CURRENTLY ENGAGING IN ANY FORM OF EXERCISE? _____

IF YES, LIST ACTIVITY, FREQUENCY AND INTENSITY: _____

2. HOW ACTIVE IS YOUR LIFESTYLE? _____ SEDENTARY ____ MODERATE PHYSICAL ACTIVITY _____ HEAVY PHYSICAL ACTIVITY

3. WHAT IS YOUR JOB TITLE IF CURRENTLY WORKING?_____
DESCRIBE THE TYPES OF ACTIVITIES INVOLVED IN YOUR JOB (HEAVY LIFTING, STAIR CLIMBING, WALKING, SITTING AT DESK, ETC):

_____

_____

4. PLEASE INDICATE YOUR EXPECTATIONS AND GOALS FOR YOUR TREATMENT:_____

_____

B. **PLEASE FILL OUT YOUR PAIN LEVELS AND MARK WHERE YOU ARE FEELING THE PAIN ON THE DIAGRAM BELOW.**

PAIN / DISCOMFORT/DIZZINESS DESCRIPTION

SYMPTON FREQUENCY:

_____ CONSTANT
_____ COMES AND GOES AT REGULAR TIMES
_____ HAPPENS ONCE IN A WHILE

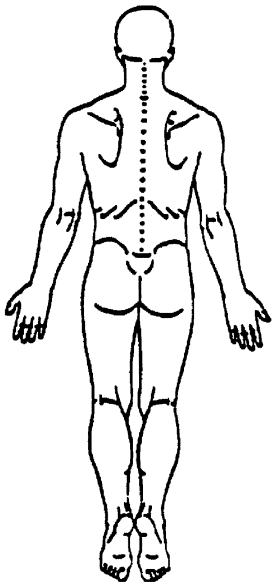
RELATIONSHIP OF SYMPTOMS TO SLEEP:

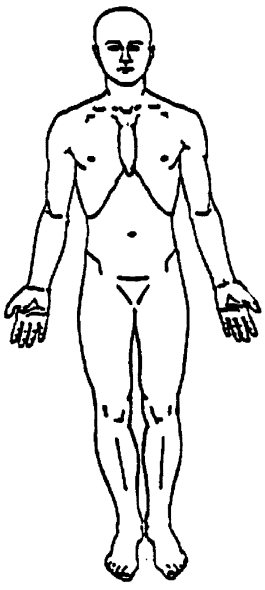
_____ WAKES FROM SLEEP
_____ PREVENTS SLEEP
_____ BETTER AFTER SLEEP

SYMPTOM SCALE- 0 BEING NONE AT ALL 10 BEING AS BAD AS IT CAN BE

AT WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENT	0	1	2	3	4	5	6	7	8	9	10
AT BEST	0	1	2	3	4	5	6	7	8	9	10

Key: /// Stabbing XXX Burning 000 Pins & Needles === Numbness





PATIENT SIGNATURE:_____ DATE:_____

MEDICATION INFORMATION

NAME:________________________________ DATE:___________________

MEDICAL HISTORY:

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

_____ ALZHEIMER'S
_____ CARDIOVASCULAR DISEASE
_____ CURRENT INFECTION
_____ CVA/STROKE
_____ DIABETES TYPE 1/TYPE 2 (CIRCLE)
_____ FIBROMYALGIA
_____ PREVIOUS FRACTURED BONES (IF SO WHICH ONES):____
_____ HIGH BLOOD PRESSURE
_____ HISTORY OF CANCER
_____ HUNTINGTON'S
_____ LUPUS
_____ MUSCULAR DYSTROPHY
_____ HIV, HEPATITIS B, HEPATITIS C
_____ OSTEOARTHRITIS
_____ PARKINSON'S
_____ PREGNANT/POSSIBLY PREGNANT
_____ RHEUMATOID ARTHRITIS
_____ TRAUMATIC BRAIN INJURY

OTHER:____

PLEASE LIST BELOW YOUR CURRENT PRESCRIPTION(S), OVER-THE-COUNTER, HERBAL, VITAMIN/ MINERALS / DIETARY (NUTRITIONAL SUPPLEMENTS) MEDICATIONS. IF YOU HAVE A CURRENT LIST OF YOUR MEDICATIONS WITH ALL OF THE BELOW INFORMATION, PLEASE PROVIDE IT TO THE FRONT OFFICE AND THEY CAN MAKE A COPY.

PRESCRIPTION MEDICATIONS:

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

OVER-THE-COUNTER / HERBAL/ VITAMIN /MINERAL / DIETARY (NUTRITIONAL SUPPLEMENT):

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

For Future Appointments Only

I ____________________________, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:____ DATE:__________________

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SIGNATURE:____ DATE:__________________

I ____________________________, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:____ DATE:__________________