OrthoRehab PHYSICAL THERAPY

THERAPIST OWNED & OPERATED

PATIENT INFORMATION

Patient's Legal Name _____ Social Security # _____ Sex M ◯ F ◯

Birth Date _____ Age _____ Marital Status: Married ◯ Single ◯ Widowed ◯ Divorced ◯ Separated ◯

Mailing Address _____ City _____ State _____ Zip _____

Home # _____ Work #_____ Cell # _____

Do we have permission to leave a message on your phone? Yes ◯ No ◯

Text or email appointment reminders/communication? Yes ◯ No ◯ Email:_____

Have you received home health services in the last 60 days? Yes ◯ No ◯

List other providers you are treating with (excluding your MD): _____

SPOUSE, PARENT/LEGAL GUARDIAN & EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Birth Date _____ Sex M ◯ F ◯

Work # _____ Cell # _____

Place of Employment _____ Occupation _____

In case of emergency, please contact: _____ Relationship _____

Home # _____ Work # _____ Cell # _____

ACCIDENT INSURANCE INFORMATION – present ID to front desk personnel

PLEASE COMPLETE: **Work Related** Yes ◯ No ◯ **Auto Accident** Yes ◯ No ◯ **Other Accident** Yes ◯ No ◯

Accident Insurance _____ Claim #_____

Adjuster's Name & Phone Number _____

Date of Accident _____ Describe _____

HEALTH INSURANCE INFORMATION - present ID & insurance card(s) to front desk personnel

Primary Insurance _____ Secondary Insurance _____

Subscriber's Name _____ Subscriber's Name _____

Birth Date of Policy Holder _____ Birth Date of Policy Holder _____

ADDITIONAL INFORMATION

Place of Employment _____ Occupation _____

Family Physician _____ Referring Physician _____

Orthopedic Rehab Inc. will arrange a payment plan and/or assist me with Care Credit, when necessary. Unless payment arrangements are made with Orthopedic Rehab Inc., past due balances will be sent to an outside collection agency. I understand that should I default on payment of my account and collection agency services are required, all costs of collection including legal fees, up to 45%, will be added to the balance of my account. This signed document covers my entire episode of care, which comprises all charges/visits/treatment throughout the duration of care.

Signature _____ Date _____

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPTIONS

I understand that:

- As part of my health care, Orthopedic Rehab Inc. originates and maintains health records describing my health records describing my health history, symptoms, examinations, diagnoses, and treatment.
- The use and disclosure of my protected health information (PHI) by Orthopedic Rehab Inc. is necessary to provide my medical care, obtain payment for my treatment, and carry out the practice's health care operations.
- Orthopedic Rehab Inc. uses PHI to communicate with you via your phone and email for purposes as appointment reminders and review requests. This information is private and used for communicating content to you, the patient. PHI is never shared or sold for any other reason.
- I have the option to receive a copy of **Orthopedic Rehab Inc. Notice of Privacy Practices** which provides a more complete description of the use and disclosure of my health information, and that I have the right to review that Notice prior to signing this consent. I also understand that Orthopedic Rehab Inc. reserves the right to change the Notice and its privacy practices at any time and that if I request, Orthopedic Rehab Inc. will mail me a copy of any revised Notice prior to its implementation.

I give Orthopedic Rehab Inc. permission to talk to the following people regarding my account and health information:

NAME:

_____

RELATIONSHIP TO PATIENT:

_____

CANCELLATION AND NO-SHOW POLICY

Your appointments are reserved especially for you and are very important to our team. We understand that sometimes schedule changes are necessary and therefore, we respectfully request at least 24-hour notice for cancellations or rescheduling of appointments. Because of the busy nature of our clinic, 24-hour notice allows us time to offer your appointment to another patient. Missed scheduled appointment, without providing 24-hour advanced notice, will be charged a $25 fee.

ASSIGNMENT OF BENEFITS AND INSURANCE DISCLAIMER

I authorize my health insurance to make payment of medical benefits directly to Orthopedic Rehab Inc. I understand that I am liable for any charges incurred should my insurance or the liable party's insurance deny payment for ANY reason.

Although Orthopedic Rehab Inc. contracts with most insurance providers, they bill my insurance as a courtesy to me. I will provide all pertinent and related insurance information, including any accident, automobile, liability, and or health insurance. Orthopedic Rehab Inc. reserves the right to lien patient recoveries from legal or insurance settlements for unpaid charge when permitted by law. Orthopedic Rehab Inc. will not bill attorneys for claims.

I am responsible for knowing what my medical and outpatient physical therapy benefits are. **I agree to pay any co-payments, co-insurance, and deductibles at the time of service and understand I may be billed for any unmet patient responsibility.**

Orthopedic Rehab Inc. will arrange a payment plan and/or assist me with Care Credit, when necessary. Unless payment arrangements are made with Orthopedic Rehab Inc., past due balances will be sent to an outside collection agency. I understand that should I default on payment of my account and collection agency services are required, all costs of collection including legal fees, up to 45%, will be added to the balance of my account. This signed document covers my entire episode of care, which comprises all charges/visits/treatment throughout the duration of care.

_____ _____

PATIENT OR GUARANTOR SIGNATURE DATE

Medical History

OrthoRehab PHYSICAL THERAPY

NAME: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

WHAT EASES YOUR PAIN? _____

WHAT MAKES YOUR PAIN WORSE? _____

WHAT ARE YOUR GOALS IN PHYSICAL THERAPY?

_____

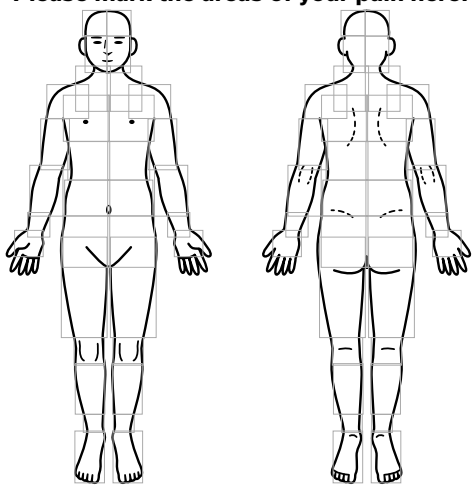
HAVE YOU HAD PREVIOUS TREATMENT FOR THIS PROBLEM?

PLEASE SPECIFY: PT ☐ CHIROPRACTIC ☐ OTHER _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS?

X-RAY ☐ CT SCAN ☐ MRI ☐ EMG ☐

Please mark the areas of your pain here:



Please mark any of the following past and current conditions that apply to you *(be as thorough as possible)*:

CONDITION	YES	NO
Allergies		
Anemia		
Anxiety		
Arthritis		
Asthma		
Autoimmune Disorder		
Cancer		
Cardiac Conditions		
Cardiac Pacemaker		
Chemical Dependency		
Circulation Problems		
Currently Pregnant		
Depression		
Diabetes		

CONDITION	YES	NO
Dizzy Spells		
Emphysema/Bronchitis		
Fibromyalgia		
Fractures		
Gallbladder Problems		
Headaches		
Hearing Impairment		
Hepatitis		
High Cholesterol		
High/Low Blood Pressure		
HIV/AIDS		
Incontinence		
Kidney Problems		
Metal Implants		

CONDITION	YES	NO
MRSA		
Multiple Sclerosis		
Muscular Disease		
Osteoporosis		
Parkinsons		
Rheumatoid Arthritis		
Seizures		
Smoking		
Speech Problems		
Strokes		
Thyroid Disease		
Tuberculosis		
Vision Problems		

Please explain any of the above marked "Yes" and describe any additional conditions or precautions:

Injury a result of a fall in the past year? YES ◯ NO ◯

Have you had two or more falls in the last year? YES ◯ NO ◯

Please describe **all surgeries** or hospitalizations *(continue on back side if necessary)*:

SURGERY TYPE: **DATE** *(mm/yyyy)*:

Please list **all medications** you are currently taking *(continue on back side if necessary)*:

MEDICATION	DOSAGE	FREQUENCY	ROUTE	REASON TAKING

SIGNATURE: _____ **DATE:** _____

OrthoRehab
PHYSICAL THERAPY

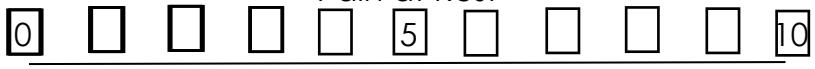
Name: _____

Date: _____

Pain Scales

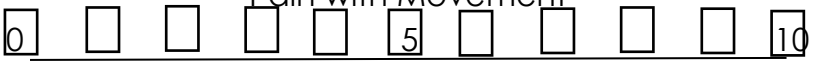
Please make a slash on the following lines to indicate your level of pain.

Pain at Rest



No Pain Worst Pain Imaginable

Pain with Movement

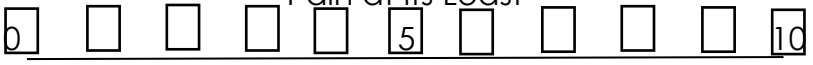


No Pain Worst Pain Imaginable

Pain at its Worst

No Pain Worst Pain Imaginable

Pain at its Least



No Pain Worst Pain Imaginable

Dizziness Handicap Inventory (DHI)

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Name: _____ Date: _____

Questions	Always	Sometimes	No
1. Does looking up increase your problem?			
2. Because of your problem, do you feel frustrated?			
3. Because of your problem, do you restrict your travel for business or recreation?			
4. Does walking down the aisle of a supermarket increase your problems?			
5. Because of your problem, do you have difficulty getting into or out of bed?			
6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?			
7. Because of your problem, do you have difficulty reading?			
8. Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?			
9. Because of your problem, are you afraid to leave your home without having someone accompany you?			
10. Because of your problem have you been embarrassed in front of others?			
11. Do quick movements of your head increase your problem?			
12. Because of your problem, do you avoid heights?			
13. Does turning over in bed increase your problem?			
14. Because of your problem, is it difficult for you to do strenuous homework or yard work?			
15. Because of your problem, are you afraid people may think you are intoxicated?			
16. Because of your problem, is it difficult for you to go for a walk by yourself?			
17. Does walking down a sidewalk increase your problem?			
18. Because of your problem, is it difficult for you to concentrate?			
19. Because of your problem, is it difficult for you to walk around your house in the dark?			
20. Because of your problem, are you afraid to stay home alone?			
21. Because of your problem, do you feel handicapped?			
22. Has the problem placed stress on your relationships with members of your family or friends?			
23. Because of your problem, are you depressed?			
24. Does your problem interfere with your job or household responsibilities?			
25. Does bending over increase your problem?			

Vestibular Questionnaire

Name _____ Date _____

Reason for today's visit _____

Onset date of symptoms _____

Symptoms related to current condition (check all that apply)

Headache ☐	Trouble falling asleep ☐	Irritability ☐
Nausea ☐	Excessive sleep ☐	Sadness ☐
Vomiting ☐	Loss of sleep ☐	Nervousness ☐
Balance issues ☐	Drowsiness ☐	More emotional ☐
Dizziness ☐	Light Sensitivity ☐	Numbness ☐
Fatigue ☐	Sound sensitivity ☐	Feeling "slow" ☐
Feeling "foggy" ☐	Difficulty concentrating ☐	Difficulty remembering ☐
Visual problems ☐	Hearing loss ☐	Ears ringing ☐
Neck pain ☐		

Symptoms increase with (check all that apply)

Rolling in bed ☐	Turning in bed ☐	Walking ☐	Straining ☐
Reading ☐	Lying down to sitting up ☐	Looking up ☐	Looking down ☐
Lying down ☐	Loud noises ☐	Sit to stand ☐	Bending/squatting ☐
Driving ☐	Coughing/sneezing ☐	Other ☐	

How long do symptoms last? ☐ <1min ☐ <30 min ☐ Hours ☐ Constant

Have you been treated for this issue prior? Y ☐ N ☐ If yes, by whom _____

Are you taking prescription or over the counter medications for this issue? Y ☐ N ☐

Are you using an assistive device due to this issue (walker, cane, wheelchair, etc.)? Y ☐ N ☐

Is there anything else you would like your physical therapist to know about your condition?

_____