

Pro-Active Physical Therapy

Patient Information

Benton Physical Therapy Malvern Physical Therapy Pro-Active Physical Therapy-Bryant

Last Name: _____ First Name: _____ Date of Birth: __/__/____

Mailing Address: _____ Sex: Male ___ Female ___

City: _____ State: _____ Zip: _____ SSN: _____

Phone # _____ E-Mail Address: _____

Marital Status: M ___ S ___ D ___ W ___

Employer Name: _____ Phone # _____ Occupation: _____

Emergency Contact Name: _____ Phone #: _____ Relation _____

Permission to Release Information to: (Name and Phone Number)

Referring Physicians Name: _____

Have you had Physical Therapy this year? Yes _____ No _____

Responsible Party Information:

Name: _____ DOB: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip: _____

Relation to Patient: Self _____ Spouse _____ Parent _____ Other _____

Employer: _____ Employer's Phone Number: _____

Parent/Guardian Signature

Date

Company Policies and Patient Consent

(Please initial by each)

Consent for Treatment

_____ I hereby agree to receive physical therapy treatments from Pro-Active Rehab DBA:
_____.

Assignment of Benefits/ Release of Information

_____ I hereby agree to assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I also understand that in the event my insurance company or financially responsible party does not pay for the service I receive I will be responsible for payment.

Financial Policy/ Estimate of Patient Responsibility

_____ I understand that it is ultimately my responsibility to understand my insurance benefits and know that all non-covered charges are my responsibility.

_____ My estimated cost with insurance benefits for Physical Therapy is:

HIPAA Notice of Privacy Practices

_____ I acknowledge that I have received the Notice of Privacy Practices.

Cancellation Policy

_____ I understand that this office requires a 24 hour notice to cancel my appointment. If I cancel less than 24 hours before or no show for my appointment I will be charged a \$25 fee.

Weight Management Plan

_____ I understand that a Weight Management Plan is available to me at this facility.

Electronic Communication

_____ I agree to let this facility to electronically send me education/information/questions regarding my condition care.

_____ I agree to allow Pro-Active Physical Therapy to take and use my photo and/or my testimonial for social media.

Signature _____ Date _____

Pro-Active Physical Therapy
PATIENT SUBJECTIVE HISTORY

NAME: _____ **AGE:** ____ **HT:** _____ **WT:** _____ **REFERRING DR:** _____

To better serve your individual needs please complete the following. Circle the appropriate choice(s) when indicated.

1) **What is your main complaint or problem?** _____
Date of onset _____ How did it occur _____

Date of surgery _____ Type _____

2) **If you have pain, please circle those words which best describe it.**

Constant Intermittent Sharp Dull Burning Throbbing Twinge Ache Numb Tingle Tight Pulling

3) **Please rate the level of your pain:** (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Agony)

4) **When do you feel: Better:** Morning Afternoon Evening Night

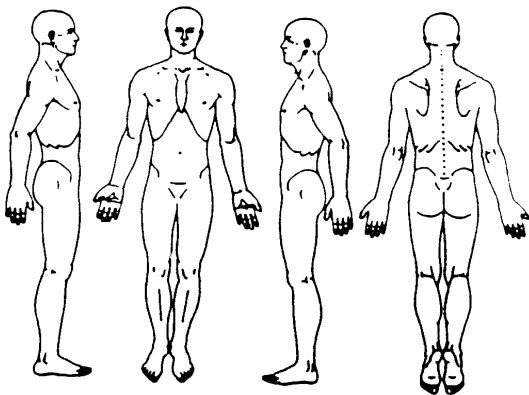
Worse: Morning Afternoon Evening Night

5) **What positions or activities make your pain better?** _____

6) **What positions or activities make your pain worse?** _____

7) **Please indicate painful areas by shading models.**

8) **What tests and/or treatment have you had for this problem? What were the findings?**



X-ray: _____

MRI: _____

CT Scan: _____

Myelogram: _____

EMG: _____

Other _____

9) **What medication(s) are you taking for this problem? Please List the names of the medications:**

Anti-inflammatory Pain killer Muscle relaxer Other: _____

10) **What is your occupation?** _____

a) **Working:** Full-time Part time Light duty Not working

b) **Physical work requirements:** sedentary light moderate heavy very heavy

c) **Job requires prolonged:** sitting standing bending walking lifting squatting driving

11) **What functional activities are you currently having problems with?**

dress/bathe job duties housework cook/eat walk stand sit drive sleep recreation _____

12) **Have you had any falls in the last year? Yes No If yes, how many falls?** _____

13) **Do you have any medical problems?**

heart blood pressure diabetes cancer arthritis seizures other _____

14) **Do you currently use tobacco products? Yes No**

15) **Language preferred:** _____ **Learning preference:** verbal visual other: _____

16) **If female are you currently pregnant or trying to be? Yes No**

17) **Do you have another appointment with your doctor? Yes No When** _____

18) **What do you hope to accomplish with physical therapy treatments?** _____

