Pro-Active Physical Therapy

Patient Information

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: Pro-Active Physical Therapy.

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)*

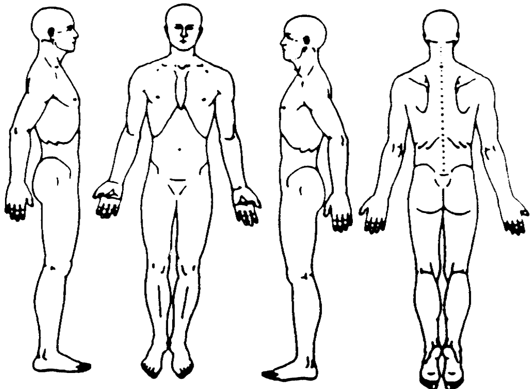
4) **When do you feel: Better:** Morning Afternoon Evening Night

   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?**__________________________________
____

MEDICATION LIST

Do you take medications daily? Yes _____ No ______

Medication	Dosage	How Often?	Route	Taken For

If you have a list of medications please give to front desk to make a copy.

Do you have any allergies? Yes ______ No ______

If yes, please list ______________________________