SCORE Physical Therapy & Wellness

PATIENT REGISTRATION

Name _____ Date _____
Last **First** **MI**

Mailing Address _____
Street **City** **State** **Zip Code**

Physical Address _____
Street **City** **State** **Zip Code**

Home Phone **w/area code** _____ Work Phone _____ Cell Phone _____

Contact Preference: ☐ Home ☐ Work ☐ Cell E-mail Address _____

Social Security Number _____ Birth date _____ Sex: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner; Registered in: _____ Spouse/Partner's Name _____ ☐ Divorced ☐ Widowed

Employer _____ Employer's Address _____

Primary Care Physician _____ Referring Physician _____

Emergency Contact _____ Relationship _____

Home Phone **w/area code** _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION – PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING

Primary Insurance _____

Subscriber's Name _____ Birth date _____

ID Number _____ Group Number _____

Secondary Insurance _____

Subscriber's Name _____ Birth date _____

ID Number _____ Group Number _____

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of accident _____ How did it happen? ☐ Auto ☐ Work ☐ Other State in which injury occurred _____

Claim Number _____ Insurance Company (worker's comp or your auto PIP) _____

Address _____ Claims Adjuster _____ Phone number _____

I verify that the above information is accurate (Signature) _____

Please tell us how you learned of our service or whom we can thank

☐ I was a **Former Patient**
☐ **Former Patient** recommendation
☐ **Health Club/Professional** recommendation
☐ **Family/Friend/Co-Worker** recommendation
☐ **Doctor** recommendation
☐ **Radio** advertisement
☐ **Yellow Page** advertisement
☐ Found you on the **Internet**
Website: _____
☐ **TV/Billboard** advertisement
☐ **Publication/Newspaper** advertisement
Publication: _____
☐ **Clinic Sign**
☐ Saw you at an **Event**
Event: _____

SCORE Physical Therapy & Wellness

PATIENT QUESTIONNAIRE / HEALTH HISTORY

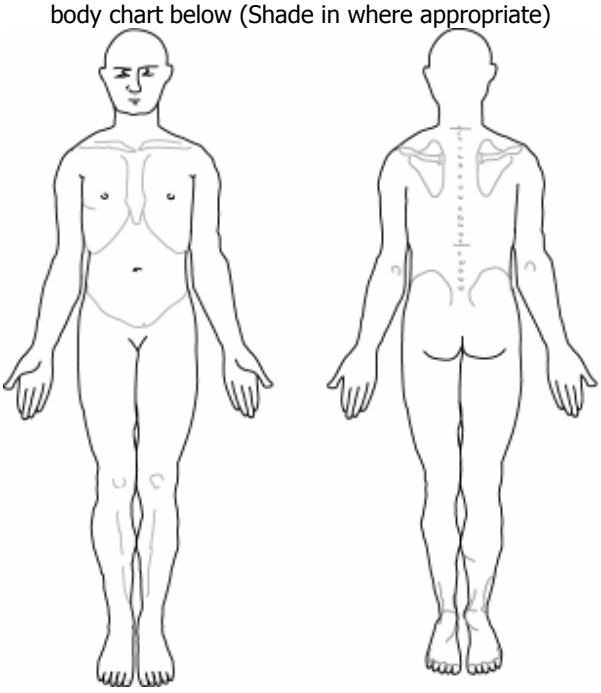
NAME: _____ **DATE:** _____

To insure you receive a complete and thorough evaluation. please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

HISTORY OF PRESENT CONDITION

1. What are your symptoms? _____
_____
_____

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade in where appropriate)



2. When did your symptoms begin?
(Please indicate a specific date if possible)_____

3. Was the **onset** of this episode gradual or sudden?(Check one)
☐ (1) gradual ☐ (2) sudden

4. Which of the following **best describes** how your injury occurred? (if your condition is post-surgical please indicate as per original injury)
☐ (1) lifting
☐ (2) a MVA (car accident
☐ (3) a fall
☐ (4) overuse (cumulative trauma)
☐ (5) trauma
☐ (6) degenerative process
☐ (7) during recreation/sports
☐ (8) running
☐ (9) a blow to the face
☐ (10) being hit by a ball
☐ (11) a dental appointment
☐ (12) throwing
☐ (13) an incident at work
☐ (14) unknown
☐ (15) other _____

5. Since onset, are your symptoms getting: (Check one)
☐ (1) better ☐ (2) worse ☐ (3) not changing

6. Have you had similar symptoms in the past? (1)☐ Yes (2) ☐ No
More than one episode? (1) ☐ Yes (2) ☐ No

7. Nature of pain/symptoms (check all that apply)
❒ (1) sharp ❒ (4) aching ❒ (7) constant
❒ (2) dull ❒ (5) periodic ❒ (8) other _____
❒ (3) throbbing ❒ (6) occasional _____

8. As the day progresses, do your symptoms: (Check one)
❒ (1) increase ❒ (2) decrease ❒ (3) stay the same

9. Does the pain wake you at night? ❒ (1) No ❒ (2) Yes
if "*yes*", is it present ❒ (1) while lying still
❒ (2) only when changing positions
❒ (3) both

10. Do you have pain/stiffness upon getting out of bed in the morning? ❒ (1) Yes ❒ (2) No

11. In what position do you sleep? (Check all that apply)
❒ (1) right side ❒ (4) back ❒ (6) back, sides, stomach
❒ (2) left side ❒ (5) chair/recliner ❒ (7) other _____
❒ (3) stomach

12. Since the onset of your current symptoms have you had:
❒ (1) any difficulty with control of bowel or bladder function
❒ (2) fever/Chills
❒ (3) any numbness in the genital or anal area
❒ (4) numbness
❒ (5) any dizziness or fainting attacks
❒ (6) weakness
❒ (7) unexplained weight change
❒ (8) night pain/sweats
❒ (9) malaise (vague feeling of bodily discomfort)
❒ (10) problems with vision/hearing
❒ (11) none of the above

13. What aggravates your symptoms? (Check all that apply)
❒ (1) sitting
❒ (2) going to/rising from sitting
❒ (3) lying down
❒ (4) walking
❒ (5) up/down stairs
❒ (6) reaching overhead
❒ (6) reaching in front of body
❒ (6) reaching behind back
❒ (6) reaching across body
❒ (7) talking, chewing, yawning, all (*circle one*)
❒ (8) recreation/sports including _____
❒ (9) repetitive activities including _____
❒ (10) household activities including _____
❒ (11) standing
❒ (12) squatting
❒ (13) sleeping
❒ (14) coughing/sneezing
❒ (15) taking a deep breath
❒ (16) looking up overhead
❒ (17) swallowing
❒ (18) stress
❒ (19) sustained bending
❒ (20) other _____

14. What relieves your symptoms? (Check all that apply)
❒ (1) sitting
❒ (2) heat
❒ (3) cold
❒ (4) stretching
❒ (5) wearing a splint/orthosis
❒ (6) rest
❒ (7) standing
❒ (8) walking
❒ (9) exercise
❒ (10) lying down
❒ (11) massage
❒ (12) medication
❒ (13) nothing
❒ (14) other_____ _____

15. Have you had any previous treatment for this condition? (Check all that apply)

- ☐ (1) none
- ☐ (2) medication (oral)
- ☐ (3) joint manipulation
- ☐ (4) exercise
- ☐ (5) massage therapy
- ☐ (6) traction
- ☐ (7) bracing/taping
- ☐ (8) injection into the spine
- ☐ (9) injection into the skin/muscles
- ☐ (10) physical therapy
- ☐ (11) hypnosis
- ☐ (12) biofeedback
- ☐ (13) TENS unit
- ☐ (14) acupuncture
- ☐ (15) bed rest
- ☐ (16) overnight hospitalization
- ☐ (17) casting
- ☐ (18) other_____

16. Have you had any of the following tests?

- ☐ (1) none
- ☐ (2) x-rays
- ☐ (3) CT Scan
- ☐ (4) MRI
- ☐ (5) Arthrogram
- ☐ (6) Stress X-ray Test (Telos)
- ☐ (7) Bone Scan
- ☐ (8) NCS
- ☐ (9) Fluoroscope
- ☐ (10) Vestibular
- ☐ (11) other_____

Test Results:_____

MEDICATION

Please list any prescription medications you are currently taking (*pain pills, injections and/or skin patches, etc.*):

_____

_____

Prescribing MD:_____Phone:_____

Are you currently taking any of the following over the counter medications?

- ☐ (1) aspirin
- ☐ (2) Tylenol
- ☐ (3) corticosteroids
- ☐ (4) antihistamines
- ☐ (5) vitamins/mineral supplements
- ☐ (6) Advil/Motrin/ Ibuprofen
- ☐ (7) other_____

PREVIOUS FUNCTIONAL LEVEL

☐ **Independent in all activities** (work, community, home, recreation)

Self-care

- ☐ Independent in all self-care activities (bathing, toileting, dressing, etc.)
- ☐ Difficulty performing self-care activities
- ☐ Need assistance with self-care activities
- ☐ Difficulty performing household chores

Social

- ☐ Need assistance with activities in community outside of home

Hobbies:_____

WORK HISTORY

Occupation_____

- ☐ (1) employed full time
- ☐ (2) employed part time
- ☐ (3) self employed
- ☐ (4) homemaker
- ☐ (5) student
- ☐ (6) retired
- ☐ (7) unemployed
- ☐ (8) other_____

Physical activities at work (check all that apply)

- ☐ (1) sitting
- ☐ (2) standing
- ☐ (3) phone use
- ☐ (4) repetitive lifting
- ☐ (5) heavy lifting
- ☐ (6) computer use
- ☐ (7) heavy equipment operation
- ☐ (8) driving
- ☐ (9) other_____

Are you currently receiving or seeking disability for this condition? ☐ (1) Yes ☐ (2) No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

☐ (1) Yes ☐ (2) No

LIVING SITUATION

- ☐ (1) live alone
- ☐ (2) live with family members/others
- ☐ (3) live with caregiver
- ☐ (4) home/apartment
- ☐ (5) retirement complex (SNF/ICF)
- ☐ (6) assisted living complex
- ☐ (7) other_____

Setting

- ☐ (1) stairs (railing)
- ☐ (2) stairs (no railing)
- ☐ (3) no stairs
- ☐ (4) ramp
- ☐ (5) elevator
- ☐ (6) uneven ground
- ☐ (7) other_____

GENERAL HEALTH

How would you rate your general health?

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Do you exercise outside of normal daily activities?

☐ 5+ days/wk ☐ 3-4 days/wk ☐ 1-2 days/wk ☐ occasionally ☐ zero

Exercise, Sports/Recreation consisting of _____

_____

Do you drink caffeinated beverages?

☐ No ☐ Yes How many/much per day_____

Do you smoke?

☐ No ☐ Yes Packs of cigarettes per day_____

What is your stress level?

☐ Low ☐ Medium ☐ High

Are you seeing any health care providers other than the physical therapist for this current condition? (Please list)_____

_____

_____

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

- ☐ Cancer (type)_____
- ☐ Depression
- ☐ Stroke
- ☐ Kidney problems
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Multiple sclerosis
- ☐ Arthritis
- ☐ Head injury
- ☐ Stomach problems
- ☐ Parkinson's disease
- ☐ Infectious diseases (i.e. hepatitis, tuberculosis, etc.)
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Lung problems
- ☐ Blood disorders
- ☐ Epilepsy/seizures
- ☐ Allergies
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Broken bone
- ☐ Circulation/vascular problems
- ☐ Other_____

Please list any recent/relevant past surgeries related to your current problem:

SURGERY **DATE**

_____

_____

_____

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated of any of the following?

- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Other_____
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Psychological condition

INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient:

Physical Therapy involves the use of many different types of physical evaluation and treatment. At SCORE Physical Therapy & Wellness, we utilize a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Potential Benefits:
May include an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I can expect to gain a greater knowledge about managing my condition and the resources available to me.

Potential Risks:
There is a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain physical therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be; nor can we guarantee that a treatment will help the condition in which you are seeking treatment for.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your physical therapist what the potential risks and benefits of a specific treatment may be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Mobilization, Neuromuscular Re-Education and Therapeutic Exercises are an integral part of most physical therapy treatment plans. All of the above have inherent physical risks associated with them. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your physical therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by SCORE Physical Therapy & Wellness. All of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

_____	_____	_____
Patient Name	Patient Signature	Date

SCORE Physical Therapy & Wellness

Patient Consent and Disclosure of
Protected Health Information and
Written Receipt of Notice of Privacy Practices

I hereby give consent for SCORE Physical Therapy & Wellness to use and disclose my Protected Health Information (PHI) to carry out Treatment, Payment and Healthcare Operations (TPO).

SCORE Physical Therapy & Wellness's Notices of Privacy Practice provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

With this consent, SCORE Physical Therapy & Wellness may:

1. Call my cell or home phone and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.
2. At any alternative location will only leave a message on my personal voicemail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.
3. Mail to my home any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
4. Answer questions about, or discuss my health and care with my family members or other designated individuals listed below:

Name:_____Relationship:_____

Name:_____Relationship:_____

I have the right to request that SCORE Physical Therapy & Wellness restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions. By signing this form I am consenting to SCORE Physical Therapy & Wellness's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, SCORE Physical Therapy & Wellness may decline to provide treatment to me.

I hereby acknowledge that I have reviewed and have been offered a copy of SCORE Physical Therapy & Wellness's Notice of Privacy Practices.

Signature of Patient or Legal Guardian:_____

Print Name:_____Date:_____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time, by contacting us via email. This authorization will remain in effect until cancelled.

Credit Card Information:

Card Type: (please circle)

○ AMEX DISCOVER MASTERCARD VISA

Card #:_____-_____-_____-_____

Expiration Date: (mm/yy)_____

CVV Code:_____

Billing Zip Code:_____

Card Holder Name:_____

I, _____, authorize SCORE Physical Therapy & Wellness, to charge my credit card for agreed upon Physical Therapy services and/or any Physical Therapy related products that SCORE distributes. I acknowledge that SCORE may charge my credit card for cancelled appointments or no-shows within 24 hour notice. I understand that my information will be saved to file for future transactions on my account.

Card Holder Signature:_____