PRECISION PHYSICAL THERAPY

PATIENT INFORMATION

Patient Name:________________________________ Birthdate:____________ Age:_____

Address: ________________________________ Home Phone:________________

City:________________ State:______ Zip:________ Cell Phone:________________

Employer:________________________________ Work Phone:________________

Preferred Contact Method for Appointment Reminders: __Home Phone __Cell Phone __Text Message __E-mail

Email Address:________________________________ Soc. Sec.#________________

By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

Marital Status: __Single __Married __Divorced __Widowed Spouse's Name:________________

Financial Responsibility: __Self __Other (If Other, please complete the Guarantor Assignment Form)

Emergency Contact:________________ Phone:____________ Relation:____________

Have you had Home Health Care in the last 30 days? __Yes __No Home Health Provider:________________

Have you had physical therapy treatment since January of this year? __Yes __No # of visits_______

Have you had chiropractic treatment since January of this year? __Yes __No # of visits_______

How did you hear about us? **Dr.**____________ **Friend**____________ **Phone Book** ____________ **Billboard**____________ **Mailer**____________ **Other**____________

I hereby authorize and consent to treatments/services for myself, or on the behalf of the above named patient, performed by the staff at Precision Physical Therapy, LLC.

Patients or Guardians Signature:________________________________ Date:________________

INSURANCE INFORMATION

Primary Insurance:________________________________ Policy #________________

Subscriber:________________________________ Policy holder SS #________________

Seconday Insurance:________________________________ Policy #________________

Subscriber:________________________________ Policy holder SS #________________

Is this physical therapy care the result of an injury related to an Auto Accident, 3rd Party incident or Employment?___Yes ___No

** If YES, please fill out the Accidental Injury Questionnaire.

AUTHORIZATION

I assign payment to Precision Physical Therapy, LLC and authorize the filing of claims to my insurance company for payment of services rendered. I am fully aware that I am ultimately responsible for deductibles, co-pays, co-insuracne and non-covered services. I authorize PPT, LLC to release any information acquired in the course of my treatment necessary to process insurance claims, obtain payment from thrid party payers or to discuss my treatment with other practitioners.

I authorize PPT,LLC to communicate with the following family or friends reguarding my current treatment, scheduling, or financial arrangements:

Name:________________________________ Relationship:________________

Name:________________________________ Relationship:________________

Name:________________________________ Relationship:________________

My signature below also acknowledges receipt of PPT, LLC Notice of Privacy Practices (effective 01/01/2019)

Patients or Guardians Signature:________________________________ Date:________________

If you do not have personal health insurance OR you do not want PPT, LLC to file claims to your personal health insurance, please read and sign below:

I have asked PPT, LLC to **NOT** file claims to my personal health insurance carrier. If I decide at a later date to have PPT, LLC send claims to my personal health insurance carrier, I understand PPT, LLC will only do so at its discretion because possible contract obligations, per-certifications, pre-authorizations, ect., may not have been preformed, which would prohibit the likelihood of benefit coverage of my services. I understand and accept responsibility for full payment or any unpaid claims.

Patients or Guardians Signature:________________________________ Date:________________

PRECISION PHYSICAL THERAPY

Patient name:______________________________ Date:______________
Occupation:______________________________
Height:______________ Weight:______________ Age:______________

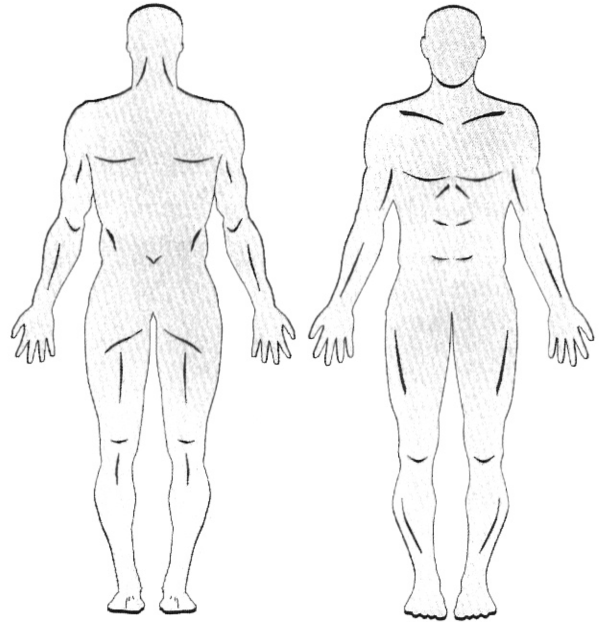
Are you currently experiencing or do you have any of the following:

- [ ] High Blood Pressure
- [ ] Cardiac Conditions
- [ ] Heart Attack
- [ ] Circulation Problems
- [ ] Pacemaker
- [ ] Seizures
- [ ] Dizzy Spells
- [ ] Diabetes
- [ ] Allergies:______________
- [ ] Fractures
- [ ] Stroke
- [ ] Arthritis
- [ ] Kidney Problems
- [ ] Liver Problems
- [ ] Cancer
- [ ] Claustrophobia
- [ ] Nervous Disorders
- [ ] Vision Problems
- [ ] Sensitivity to Heat
- [ ] Sensitivity to Cold
- [ ] Speech Problems
- [ ] Metal Implants
- [ ] AIDS
- [ ] HIV
- [ ] Bronchitis
- [ ] Tuberculosis
- [ ] Hepatitis A B C
- [ ] Ulcers
- [ ] Osteoporosis
- [ ] Bladder/Incontinence Problems
- [ ] Frequent Falls
- [ ] Headaches
- [ ] Hearing Problems
- [ ] I am or may be Pregnant
- [ ] Other:______________
- [ ] ______________

Where is your pain?

Please use the following symbols to mark the areas you feel pain.

Pain:
Numbness: ///
Pins/Needles::::
Shooting: xxx



Pain Intensity:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN <--> **SEVERE PAIN**

Please describe your pain:

__Sharp
__ Shooting
__Burning
__Dull
__Throbbing
__Stabbing
__ Pulling
__ Ache
__ Tingling
__Numb
__Heavy
__Constant

What alleviates your pain: Rest Walking Exercise Heat Ice Medication
Other:______________________________

What aggravates your pain: Lifting Walking Sitting Standing Sleeping
Other:______________________________

Please list X-rays, MRI, or other test that were performed for this condition:______________
Please list any Surgery/Hospitalization & Date:______________
Previous treatments, physical therapy, chiropractic, injections:______________
Please list hobbies/exercise and frequency:______________
Please list activities you have difficulty preforming due to pain/symptoms :

	minimal	moderate	severe	unable to preform	getting better/worse/same
Driving	______	______	______	______	______________
walking	______	______	______	______	______________
bending at the waist	______	______	______	______	______________
getting up from a chair	______	______	______	______	______________
reaching	______	______	______	______	______________
other:______________	______	______	______	______	______________

Please list any current medications (including prescription, over-the-counter, and herbal):

	Name	Dosage	frequency	Administration
1	______________	______________	______________	Oral, Patch, Topical, Other
2	______________	______________	______________	Oral, Patch, Topical, Other
3	______________	______________	______________	Oral, Patch, Topical, Other
4	______________	______________	______________	Oral, Patch, Topical, Other
5	______________	______________	______________	Oral, Patch, Topical, Other

Patients or Guardians Signature:______________________________ Date:______________