NEW PATIENT INTAKE FORM

Superior Physical Therapy

PATIENT INFORMATION

PATIENT'S FULL NAME (LAST, FIRST, MI)			
ADDRESS	**CITY**	**STATE**	**ZIP**
BIRTH SEX **( ) Male ( ) Female**	**SSN**	**DOB (MM/DD/YYYY)**	
HOME PHONE **OK TO CALL**	**CELL PHONE** **OK TO CALL**	**WORK PHONE** **OK TO CALL**	
EMAIL	**HOW DID YOU HEAR ABOUT US?**		
REFERRING PHYSICIAN	**ADDRESS**	**PHONE**	
EMERGENCY CONTACT NAME	**RELATION**	**PHONE**	

INJURY/ILLNESS INFORMATION

DIAGNOSIS	**DATE OF INJURY (MM/DD/YYYY)**	**DATE OF SURGERY (MM/DD/YYYY)**
NATURE OF INJURY/ILLNESS	**TYPE OF INJURY** **ON THE JOB** **MOTOR VEHICLE** **OTHER**	

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		**PHONE NUMBER**	
SUBSCRIBERS NAME	**SUBSCRIBERS DOB (MM/DD/YYYY)**	**RELATION**	
ID#	**GROUP ID#**	**EMPLOYER / PHONE**	
INSURANCE ADDRESS			

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY		**PHONE NUMBER**	
SUBSCRIBERS NAME	**SUBSCRIBERS DOB (MM/DD/YYYY)**	**RELATION**	
ID#	**GROUP ID#**	**EMPLOYER / PHONE**	
INSURANCE ADDRESS			

GUARANTOR INFORMATION

GUARANTOR NAME	**PHONE**		**DOB**
ADDRESS	**CITY**	**STATE**	**ZIP**

I acknowledge that all the information that I have supplied on these forms is true, accurate, current, and complete.

Superior Physical Therapy Medical Screening Questionnaire

Superior Physical Therapy

Name: _____ **Date:** _____ **Age:** _____

Are you latex sensitive? ❑**Yes** ❑**No**

Do you smoke? ❑**Yes** ❑**No**

Do you have a pacemaker? ❑**Yes** ❑**No**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ❑**Yes** ❑**No**

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue	❑ numbness or tingling	❑ constipation
❑ fever/chills/sweats	❑ muscle weakness	❑ diarrhea
❑ nausea/vomiting	❑ dizziness/lightheadedness	❑ shortness of breath
❑ weight loss/gain	❑ heartburn/indigestion	❑ fainting
❑ difficulty maintaining balance while walking	❑ difficulty swallowing	❑ cough
❑ falls	❑ changes in bowel or bladder function	❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer	❑ depression	❑ thyroid problems
❑ heart problems	❑ lung problems	❑ diabetes
❑ chest pain/angina	❑ tuberculosis	❑ osteoporosis
❑ high blood pressure	❑ asthma	❑ multiple sclerosis
❑ circulation problems	❑ rheumatoid arthritis	❑ epilepsy
❑ blood clots	❑ other arthritic condition	❑ eye problem/infection
❑ stroke	❑ bladder/urinary tract infection	❑ ulcers
❑ anemia	❑ kidney problem/infection	❑ liver problems
❑ bone or joint infection	❑ sexually transmitted disease/HIV	❑ hepatitis
❑ chemical dependency (i.e., alcoholism)	❑ pelvic inflammatory disease	❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer	❑ diabetes	❑ tuberculosis
❑ heart problems	❑ stroke	❑ thyroid problems
❑ high blood pressure	❑ depression	❑ blood clots

During the past month have you been feeling down, depressed or hopeless? ❑**YES** ❑**NO**
During the past month have you been bothered by having little interest or pleasure in doing things? ❑**YES** ❑**NO**
If yes to either, is this something with which you would like help? ❑**YES** ❑**YES, but NOT today** ❑**NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

_____

_____

Have you ever taken steroid medications for any medical conditions? ❑**YES** ❑**NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ❑**YES** ❑**NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

_____

_____

What date (roughly) did your present problem start?_____

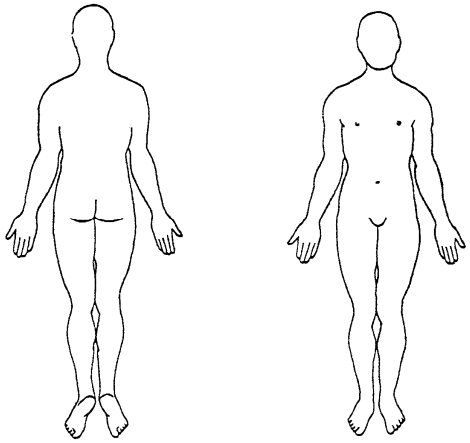
My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

Treatment received so far for this problem (chiropractic, injections, surgery, etc): _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:



↓ **Shooting/sharp pain**
O Dull/aching pain
Ⅲ Numbness
= Tingling

My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Circle your **current** level of pain while completing this survey: …0…1…2…3…4…5…6…7…8…9…10…

Circle the **best** your pain has been during the past 24 hours: …0…1…2…3…4…5…6…7…8…9…10…

Circle the **worst** your pain has been during the past 24 hours: …0…1…2…3…4…5…6…7…8…9…10…

Easing Factors: Identify **up to 3** important positions or activities that make your symptoms *better*:
1. _____
2. _____
3. _____

Aggravating Factors: Identify **up to 3** important activities that you are unable to do or are having difficulty with as a result of your problem.
1. _____
2. _____
3. _____

Therapist Use:
Rating: ____
Rating: ____
Rating: ____

Average: ____

Therapist Use:
Unable to perform 0 1 2 3 4 5 6 7 8 9 10 Able to perform at same level as before injury (problem)

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After activity
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After activity

Consent to Treatment

I consent to and authorize Professional Occupational & Physical Therapy to administrator rehabilitation therapy treatment. I understand and am informed that, as in the practice of medicine, rehabilitation therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform my provider of rehabilitation therapy about any health problems or allergies I have, as well as medications I am taking. I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or treatment results from the rehabilitation therapy.

Electrical Stimulation Pad Policy

I acknowledge that I have read and understand the Electrical Stimulation Pad Policy and agree to abide by its terms.

Authorization to Release / Obtain Information

I hereby authorize the release of my patient health care information for the purposes of treatment or payment, to my physician, insurance company, adjustor, attorney, or other health care organizations pertinent to my case. Further, I authorize Professional to obtain needed information from my physician, insurance company, adjustor, attorney and any other health care organization pertinent to my case. These correspondence can be made via mailings, telephone and/or facsimile.

Insurance Eligibility

Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time a claim is received. We provide you with the Initial information as it is outlined by your insurance company. It is your responsibility to fully understand your insurance benefits.

Financial Responsibility

Payment is due at the time of treatment. I agree to pay Professional all amounts that are due for services rendered which are not otherwise paid for by my insurance plan I on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due for services rendered including, without limitation, reasonable attorney's fees.

Assignment & Release of Benefits

I hereby appoint Superior Physical Therapy as my authorized representative, and assign to it my right, to file for, receive and recover any and all monies payable for the care which it rendered to me from any third party claims payment source, including my health insurer, Medicare, Medicaid or other governmental program (collectively, my "Plan"), while I was eligible to receive such claim payment. I authorize you to send and receive documentation related to my treatment to, and consent to your discussing my treatment with, my Plan." I also authorize SPT to take any and all actions necessary to assert and pursue my legal rights to receive such claim payment under the terms of my Plan through any appeals and/or grievances and/or litigation and/or arbitration available to me for such purpose. As the assignor of the foregoing payment amounts, I direct that such payment be sent by my Plan to SPT and, in the case that payment is made by my Plan to me, I agree to remit such payment in full to SPT not later than ten (10) days after my receipt.

The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information printed above.

Patient Signature (Parent/Guardian if patient under 18 years)	Printed Name	Date

Superior Physical Therapy

SUPERIOR PHYSICAL THERAPY

HIPAA Patient Information Consent Form

Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Superior Physical Therapy. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Assignment of Benefits and Insurance Proceeds

I authorize payment of medical benefits to Superior Physical Therapy for services rendered. Superior Physical Therpay will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

Patient Information Consent Form (HIPAA)

I have read and fully understand Superior Physical Therapy Notice of Information Practices. I understand that Superior Physical Therapy may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Superior Physical Therapy will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Superior Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Supeiror Physical Therapy has 30 days to respond to my request.

Release of Information

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Designated Individuals Authorization

I, _____, hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print "none" below.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I have read and understand the above consents, assignment of benefits, release of information, and designated individuals authorization above.

_____

Patient Signature _____ Date_____

PATIENT NAME: _____ ID#: _____ DATE: _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

LEFS – INITIAL VISIT

Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____