Patient Questionnaire/Medical History Form

Under Medicare and State practice acts, we are required to obtain a complete medical history on all patients. The information is protected under HIPAA laws. Please answer the below to the best of your ability.

Last Name: _____ First Name: _____ MI: _____ Date: ____/____/____

DOB: ____/____/____ Age: _____ Sex: M / F Height: _____ Weight: _____ Hand Dominance: R / L

How did you hear about us? _____

Referring Doctor: _____ Primary Care Doctor: _____

If accident, please indicate where occurred: HOME AUTO WORK SPORTS OTHER Next Doctor's Visit: ____/____/____

Occupation: _____ Current Work Status: _____

Do you have lifting restrictions? Y / N Do you live alone? Y / N Do you have stairs where you live? Y / N

What is the reason for your visit: _____

Briefly describe how/when your problem began: _____

What goals do you expect to achieve with therapy? _____

Date of/onset of injury: ____/____/____ Date of Surgery: ____/____/____ Type of Surgery: _____

Prior treatment for your current chief complaint (circle all that apply) ☐ No treatment received yet

Physical Therapy	Chiropractic Care	Pain Management	Accupuncture
Massage	Personal Training	Athletic Training	Brace/Tape
Surgical Interventions	Injections	Mechanical Traction	Other: _____

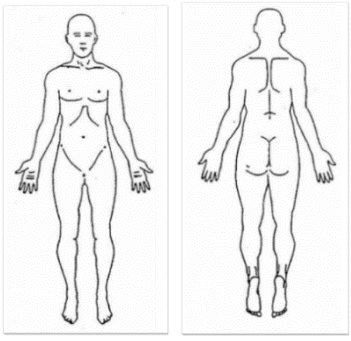
Diagnostic Testing: (circle all that apply)

X-Ray MRI CTScan EMG Doppler Ultrasound Bloodwork Bone Scan Other:_____

Please list body part tested and test date: _____

Have you had similar symptoms in the past: Y / N

Circle where your pain is:



Where did your pain start? _____

Is your pain: ☐ worsening ☐ improving ☐ no change

Describe your pain: ☐ sharp ☐ dull ☐ aching ☐ throbbing

☐ **b**urning ☐ shooting ☐ stabbing ☐ squeezing ☐ constant

What makes it worse? _____

What makes it better? _____

Does pain wake you from sleep? _____

Please rate your pain on 0-10 scale (0 is no pain, 10 is worst imaginable)

Least: 0 1 2 3 4 5 6 7 8 9 10 Worst: 0 1 2 3 4 5 6 7 8 9 10 Present: 0 1 2 3 4 5 6 7 8 9 10

Do you have any tingling/numbness/ loss of sensation: Y / N if so, where? _____

Do you have any weakness? Y / N if so, where? _____
Do you have any swelling? Y / N if so, where? _____
Have you fallen two (2) or MORE TIMES within the past 12 months? Y / N
Have you sustained an injury as a result of these falls: Y / N

PRO STAFF PHYSICAL THERAPY

Do you use any of the following? Cane Walker Crutches Wheelchair

Over the last 2 weeks, how often have you been bothered by any of the following?:

		Not at all	Several Days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things:	0	1	2	3
2.	Feeling down, depressed, or hopeless:	0	1	2	3

Please circle Yes or No if you have or had any of the following conditions:

High Blood Pressure	Y / N	Heart Attack	Y / N	Osteoarthritis	Y / N
High Cholesterol	Y / N	Cardiac Stents	Y / N	Rheumatoid Arthritis	Y / N
Diabetes	Y / N	Cardiac Bypass	Y / N	Osteoporosis/Osteopenia	Y / N
Acid Reflux or Ulcers	Y / N	Angina/Chest Pain	Y / N	Scoliosis	Y / N
Thyroid disorder	Y / N	Congestive Heart Failure	Y / N	Headaches/Migraines	Y / N
Bleeding disorder	Y / N	Emphysema	Y / N	Cancer (site_____)	Y / N
Seizures/Epilepsy	Y / N	COPD	Y / N	Recent Infection	Y / N
Lyme Disease	Y / N	Asthma	Y / N	Multiple Sclerosis	Y / N
Fibromyalgia	Y / N	Stroke	Y / N	Depression	Y / N
Lupus	Y / N	Dizziness or Fainting	Y / N	Currently Pregnant	Y / N
Kidney Stones	Y / N	Hepatitis	Y / N	# of weeks _____	

Please circle any you have: Glasses Contacts Dentures Pacemaker Metal Impant Hearing Aides

Please circle any of the following that apply:
Mentral Disorder: (Type)_____ Dementia/Alzheimer HIV/AIDS Parkinson's Hepatitis (Type): _____

Are you a tobacco user? Y / N
List all allergies you may have: _____

List all previous surgeries and dates (within previous 5yrs):

_____

_____

_____

List all medications/supplements you are taking, include dosage and frequency:

_____

_____

_____

Emergency Contact? Name_____ Relation _____ Phone_____

To the best of my ability, I have provided and included all pertinent medical information

Patient/Guardian signature: _____ Date: ____/____/_____

Medical History reviewd by physical or occupational therapist and utilized in determining the plan of care

Therapist signature: _____ Date: _____/____/_____

PRO STAFF
PHYSICAL THERAPY

New Patient Acknowledgements Patient Name: _____

Consent to Evaluate and Treat **Initial** _____

I do hereby consent to the evaluation and treatment by ProStaff Physical Therapy. I understand that it is my right to accept or refuse any treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

Notice of Privacy Practices **Initial** _____

I hereby acknowledge that I have reviewed ProStaff Physical Therapy Notice of Privacy Practices and agree to the practice's use and disclosure of my protected health information for treatment, payment and health care operations. I further acknowledge that a copy of the current notice is available at the front desk and online, and that I may request a copy of any amended Notice of Privacy Practices at any time.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

_____

_____

Release of Information **Initial** _____

I authorize ProStaff Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third-party payor or other entity providing payment for my health care (such as insurance company, employer, or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with custodians of records. I consent to the release of medical information for communication and care coordination on my behalf to:

_____

Assignment of Benefits **Initial** _____

I request that payment of Medicare and/or other insurance benefits be made on my behalf to ProStaff Physical Therapy for any services furnished by ProStaff Physical Therapy.

Financial Agreement **Initial** _____

The undersigned agrees, whether signing as agent or patient, that she/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of ProStaff Physical Therapy. ProStaff Physical Therapy will verify insurance benefits on behalf of the patient as a courtesy. However, verification is not a guarantee of payment and patients can call their insurance companies as well to confirm this information. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

PRO STAFF
PHYSICAL THERAPY

Insurance Coverage **Initial _____**

I understand that if I fail to disclose any effective insurance coverage at the time of this signing or after the first service date when said insurance became effective, I will be held responsible for any balances not covered by said insurance. This includes balances due to lack of authorization.

_ **I do not have secondary coverage.** _ **I choose not to use my secondary coverage.**

Insurance Benefits **Initial _____**

Please understand that your insurance policy is a contract between you and your insurance company. While we may accept your insurance as payment, your contract with us is a separate agreement. In other words, if your insurance refuses to cover a certain treatment or otherwise fails to pay us, your contr4act with us still exists and you are responsible for payment personally.

Your Responsibility **Initial _____**

Co-pays, deductibles, and self-pay payments are due at the time of service. We accept Mastercard, Visa, cash, check or money order **only.** We will assist with a budgeted payment plan based on individual need. In any event, if you request such a plan, this will be set up directly with our practice billing department. If at any point you have a problem regarding billing and payment please speak with the Office Coordinator of the clinic.

Cancellation Policy **Initial _____**

We require 24 hours notice in the event of a cancellation. It is your responsibility when you call in to have an alternative time in mind that will ensure you receive your full prescribed number of treatments that week whenever possible. There is a $25.00 charge for a no show or cancellation without proper notice. This charge will not be covered by your insurance company and will have to be paid by you personally. You should understand that when you no-show, three people get hurt: 1) yourself, because you are not receiving the treatment you need as prescribed by the doctor and our staff, 2) the therapist, who now has a "vacancy" in their schedule since the time was personally reserved for you, and 3) another patient, who could have been scheduled for treatment if you had given us proper notice.

Arrival Policy **Initial _____**

If you are late, we may not be able to provide your full treatment.
If you arrive early, we will do our best to get you in as soon as possible. Most of the time you'll have to wait until your scheduled time to be seen because there are other patients who are still in treatment.

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

_____ _____ _____

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