Home Town
Physical Therapy

Patient Registration

PLEASE FILL OUT THE HIGHLIGHTED SECTIONS THEN SIGN & DATE THE BOTTOM

Name _____ Date _____
Last First Middle

Mailing Address _____
Street/PO Box City State Zip Code

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____ Date of Birth _____

Email Address _____

Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer _____ Occupation _____

Referring Physician _____ Family Physician _____

Injury/Diagnosis/Body Part Injured _____

Patients younger than 18 please list parent(s)/legal guardian(s) _____

Emergency Contact _____ Relationship _____ Phone _____

INSURANCE INFORMATION – PLEASE GIVE YOUR CARDS TO RECEPTIONIST FOR COPYING

Primary Insurance _____

Insured's Name _____ Relation to Patient _____ Birth Date _____

ID Number _____ Group Number _____

Secondary Insurance _____

Insured's Name _____ Relation to Patient _____ Birth Date _____

ID Number _____ Group Number _____

WORKER'S COMPENSATION / MOTOR VEHICLE ACCIDENT

Date of Injury _____ Injury due to: ☐ Worker's compensation ☐ Auto Accident

Insurance Company (worker's comp or auto ins.) _____

Address _____ Phone _____

Claim Number _____ Adjuster / Claim Manager _____

PLEASE TELL US HOW YOU LEARNED OF OUR SERVICE OR WHOM WE CAN THANK.

☐ Yellow page advertisement
☐ Web page
☐ Newspaper advertisement
☐ TV advertisement
☐ Doctor Recommendation
☐ Family/Friend recommendation
☐ I was a former patient
☐ Other _____

_____ _____
Signature: Patient or Parent/Legal Guardian if patient is under 18 Date

CONTINUED ON OTHER SIDE →

Home Town
Physical Therapy

PATIENT WORKSHEET

PROBLEM AREA (please check one):
☐ Upper Extremity (A,D) ☐ Lower Extremity (B,F)
☐ Cervical/Thoracic (C,D) ☐ Lumbar (D,F) ☐ TMJ (C,E)

NAME _____

DATE _____ ☐ Initial Visit ☐ Discharge Visit

FUNCTIONAL INDEX

PART I: *Answer all five sections in Part 1. Choose the one answer in each section that best describes your condition.*

WALKING
☐ Symptoms do not prevent me walking any distance.
☐ Symptoms prevent me walking more than 1 mile.
☐ Symptoms prevent me walking more than ½ mile.
☐ Symptoms prevent me walking more than ¼ mile.
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

WORK
(*Applies to work in home and outside*)
☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all (only light duty).
☐ I cannot do any work at all.

PERSONAL CARE
(*Washing, Dressing, etc.*)
☐ I can manage all personal care without symptoms.
☐ I can manage all personal care with some increase symptoms.
☐ Personal care requires slow, concise movements due to increased symptoms.
☐ I need help to manage some personal care.
☐ I need help to manage all personal care.
☐ I cannot manage any person care.

SLEEPING
☐ I have no trouble sleeping.
☐ My sleep is mildly disturbed (less than 1 hr. sleepless).
☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

RECREATION/SPORTS
(*Indicate sport if appropriate* _____)
☐ I am able to engage in all my recreational/sports activities without increased symptoms.
☐ I am able to engage in all my recreational/sports activities with some increased symptoms.
☐ I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
☐ I am able to engage in a few of my usual recreational/sports activities because of increased symptoms.
☐ I can hardly do any recreational/sports activities because of increase symptoms.
☐ I cannot do any recreational/sports activities at all.

ACUITY

(*Answer on initial visit.*)
How many days ago did onset/injury occur? _____days

Functional: ___/___ Impairment: ___/___

PART II: *Choose the one answer that best describes your condition in the sections designated by your therapist.*

A. UPPER EXTREMITY

CARRYING
☐ I can carry heavy loads without increased symptoms.
☐ I can carry heavy loads with some increase symptoms.
☐ I cannot carry heavy loads overhead, but I can manage if they are positioned close to my trunk.
☐ I cannot carry heavy loads, but I can manage light to medium loads if they are positioned close to my trunk.
☐ I can carry very light weights with some increase symptoms.
☐ I cannot lift or carry anything at all.

DRESSING
☐ I can put on a shirt or blouse without symptoms.
☐ I can put on a shirt or blouse with some increase symptoms.
☐ It is painful to put on a shirt or blouse, I am slow and careful.
☐ I need some help but I manage most of my shirt or blouse dressing.
☐ I need help in most aspects of putting on my shirt or blouse.
☐ I cannot put on a shirt or blouse at all.

REACHING
☐ I can reach to a high shelf to place an empty cup without increase symptoms.
☐ I can reach to a high shelf to place an empty cup with some increase symptoms.
☐ I can reach to a high shelf to place an empty cup with a moderate increase in symptoms.
☐ I cannot reach to a high shelf to place an empty cup, but I can reach up to a lower shelf without increase symptoms.
☐ I cannot reach up to a lower shelf without increased symptoms, but I can reach counter height to place an empty cup.
☐ I cannot reach my hand above waist level without increased symptoms.

B. LOWER EXTREMITY

STAIRS
☐ I can walk stairs comfortably without a rail.
☐ I can walk stairs comfortably, but with a crutch, cane or rail.
☐ I can walk more than 1 flight of stairs, but with increased symptoms.
☐ I can walk less than 1 flight of stairs.
☐ I can manage only a single step or curb.
☐ I an unable to manage even a step or curb.

UNEVEN GROUND
☐ I can walk normally on uneven ground without loss of balance or using a cane or crutches.
☐ I can walk on uneven ground, but with loss of balance or with the use of a cane or crutches.
☐ I have to walk very carefully on uneven ground without using a cane or crutches.
☐ I have to walk very carefully on uneven ground even when using a cane or crutches.
☐ I have to walk very carefully on uneven ground and require physical assistance to manage it.
☐ I am unable to walk on uneven ground.

CONTINUED ON THE OTHER SIDE →

Home Town
Physical Therapy

Patient Questionnaire / Health History

Name: _____

Date: _____

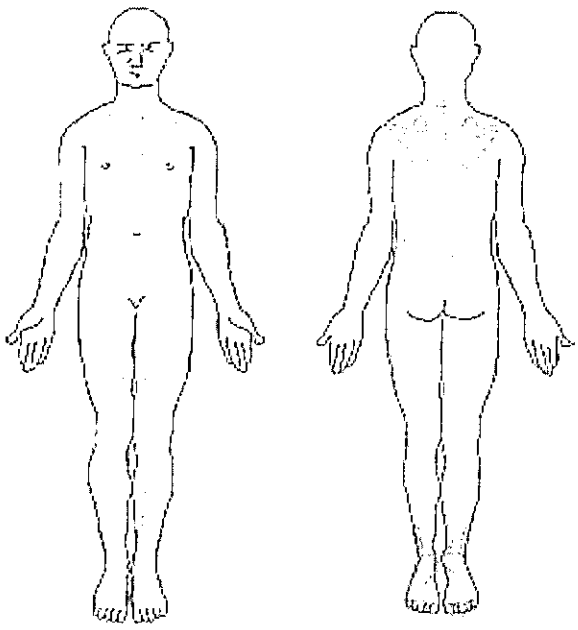
HISTORY OF PRESENT CONDITION

What are your symptoms? _____

_____

_____

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



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

Was the onset of this episode gradual or sudden?

□ gradual □ sudden

What aggravates your symptoms?

- □ sitting
- □ going to/rising from sitting
- □ lying down
- □ walking
- □ up/down stairs
- □ reaching overhead
- □ reaching in front of body
- □ reaching behind back
- □ reaching across body
- □ talking, chewing, yawning (circle all that apply)
- □ recreation/sports
- □ repetitive activities
- □ household activities
- □ standing
- □ squatting
- □ sleeping
- □ coughing/sneezing
- □ taking a deep breath
- □ looking up overhead
- □ swallowing
- □ stress
- □ sustained bending
- □ other_____

_____

_____

What relieves your symptoms?

- □ sitting
- □ heat
- □ cold
- □ stretching
- □ wearing a splint/brace
- □ rest
- □ standing
- □ walking
- □ exercise
- □ massage
- □ medication
- □ nothing
- □ lying down
- other _____

Since the onset of your symptoms have you had:

- □ difficulties with control of bowel or bladder function
- □ fever/chills
- □ any numbness in the genital or anal area
- □ numbness
- □ any dizziness or fainting attacks
- □ weakness
- □ unexplained weight change
- □ night pain/sweats
- □ malaise (vague feeling of bodily discomfort)
- □ problems with vision/hearing
- □ none of the above

MEDICATION

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

_____

_____

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

- □ aspirin
- □ Tylenol
- □ corticosteroids
- □ vitamins/mineral supplements
- □ Advil/Motrin/Ibuprofen
- □ antihistamines
- □ Other_____

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions?

- □ 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

Home Town
Physical Therapy

Billing Policies

As a courtesy to our patients, Home Town Physical Therapy will bill your insurance company if we are provided with all the necessary information. To avoid any confusion our policies are listed below.

READ & INITIAL THE HIGHLIGHTED SECTIONS BELOW THEN SIGN & DATE THE BOTTOM

_____ **AUTO ACCIDENT**: We will bill your personal auto insurance policy; WE DO NOT BILL 3RD PARTY LIABILITY INSURANCES:

A. Name of insured
B. Insurance company billing address
C. Claim number and date of accident
D. Adjuster's name and telephone number

If you are injured by someone else and don't have Personal Injury Protection coverage we require payment up front for 100% of the treatment and will offer you the cash pay discount (see below), but we will NOT forward bills to any insurance company, it will be your responsibility to forward claims to the responsible party. *** We do NOT handle cases where a lien agreement is involved. ***

_____ **ON THE JOB INJURIES**: If you are injured on the job and have an open claim we will bill the worker's compensation insurance and no payment by the patient is required. You must provide us with the following:

A. Worker's Compensation insurance company
B. Claim number and date of injury
C. Adjusters name and telephone number

If your claim is denied by worker's compensation we will bill your primary health insurance-as long as you provide our office the pertinent information listed above. You are then responsible for any balance not covered.

_____ **CASH**: As a courtesy to our patients who do not have health insurance coverage or prefer to pay on a cash basis; we offer a cash based fee schedule for those patients/individuals who pay on the same day services are provided.

_____ **PRIVATE INSURANCE:** To ensure timely payments, you must identify the following information on the first visit:

A. Name of insured
B. Insurance company telephone number
C. ID number/group number and/or claim number
D. Provide us with a copy of your insurance card

If no payment is received from your insurance within 90 days, we will require payment from the patient to keep the account from going to collections (unless other arrangements are made). HOWEVER, you are still responsible for copays, %, deductible, etc. We also bill secondary insurances.

OTHER INTAKE INFORMATION

_____ **INVENTORY ITEMS**: If inventory items are necessary, you will be required to pay for those items on the day you receive them from our office. We will bill your insurance company if requested, but you are ultimately responsible for any balance due, including shipping, regardless if the insurance company discounts the item. If your insurance does pay, we will reimburse your portion.

_____ **LATE FEES**: Any balance unpaid after 90 days will begin to accrue interest at annual rate of 12% until paid in full.

_____ I authorize Home Town Physical Therapy to release any medical information to medical providers and their staff, my insurance company, and management groups pertaining to my physical therapy treatment.
I also authorize you to release my information to the following:
PLEASE LIST ANYONE YOU WOULD LIKE TO US TO RELEASE MEDICAL INFO TO: (spouse, significant other, Parent/legal guardian, caretaker, etc.) _____

_____ I understand if I have 3 no show appointments with out a 24-hour notice it may result in a $25.00 fee that I will be required to remit prior to being rescheduled for further therapy.

_____ I acknowledge that I have received and read the notice of privacy practices.

_____ _____
Signature: Patient or Parent/Legal Guardian if patient is under 18 Date

C. CERVICAL/TMJ

CONCENTRATION

- ☐ I can concentrate fully when I want to with no difficulty
- ☐ I can concentrate fully when I want to with slight difficulty
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come less than 3 per week.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come 4 or more per week.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all of the time.

READING

- ☐ I can read as much as I ant without increase symptoms.
- ☐ I can read as much as I want with slight symptoms.
- ☐ I can read as much as I want with moderate symptoms.
- ☐ I cannot read as much as I want due to moderate symptoms.
- ☐ I can hardly read at all because of sever symptoms.
- ☐ I cannot read at all.

D. LUMBAR/CERVICAL/UPPER EXTREMITY

DRIVING

- ☐ I can drive or travel without any extra symptoms.
- ☐ I can drive or travel as long as I want with slight symptoms.
- ☐ I can drive or travel as long as I want with moderate symptoms.
- ☐ I cannot drive or travel as long as I want due to moderate symptoms.
- ☐ I can hardly drive or travel at all due to severe symptoms.
- ☐ I cannot drive or travel at all.

LIFTING

- ☐ I can lift heavy weights without extra symptoms.
- ☐ I can lift heavy weights but it gives extra symptoms.
- ☐ My symptoms prevent me from lifting heavy weights but I manage if they are conveniently positioned. (e.g. on a table)
- ☐ My symptoms prevent me from lifting heavy weights but I manage light to medium weights if they are conveniently placed.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

E. TMJ

TALKING

- ☐ I can talk without any increased symptoms.
- ☐ I can talk as long as I want with slight symptoms in my jaws.
- ☐ I can talk as long as I want with moderate symptoms in my jaws.
- ☐ I cannot talk as long as I want because of moderate symptoms in my jaws.
- ☐ I can hardly talk at all due to of severe symptoms in my jaws.
- ☐ I cannot talk at all.

EATING

- ☐ I can eat whatever I want without symptoms.
- ☐ I can eat whatever I want but it gives extra symptoms.
- ☐ Symptoms prevent me from eating regular food, but I can manage if I avoid hard foods.
- ☐ Symptoms prevent me from chewing anything but soft foods.
- ☐ I can chew soft foods occasionally, but mainly stick to liquid diet.
- ☐ I cannot chew at all and maintain a liquid diet.

F. LUMBAR/LOWER EXTREMITY

STANDING

- ☐ I can stand as long as I want without increase symptoms.
- ☐ I can stand as long as I want, but it give me extra symptoms.
- ☐ Symptoms prevent me from standing for more than 1 hour.
- ☐ Symptoms prevent me from standing more than 30 minutes.
- ☐ Symptoms prevent me from standing more than 10 minutes.
- ☐ Symptoms prevent me from standing at all.

SQUATTING

- ☐ I can squat fully without the use of my arms for support.
- ☐ I can squat, but with symptoms or using my arms for support.
- ☐ I can squat ¾ of my normal depth, but less than fully.
- ☐ I can squat ½ of my normal depth, but less than ¾.
- ☐ I can squat ¼ of my normal depth, but less than ½.
- ☐ I am unable to squat any distance due to symptoms.

SITTING

- ☐ I can sit in any chair as long as I want.
- ☐ I can only sit in my favorite chair as long as I want.
- ☐ My symptoms prevent me sitting more than 1 hour.
- ☐ My symptoms prevent me sitting more than ½ hour.
- ☐ My symptoms prevent me sitting more than 10 minutes.
- ☐ My symptoms prevent me from sitting at al

PAIN INDEX

Please indicate the worst your pain has been in the last 24 hours on the scale below

No pain — Worst Pain Imaginable

IMPROVEMENT INDEX

Please indicate the amount of improvement you have made since the beginning of your physical therapy treatment on the scale below.

No improvement — Full Recovery

WORK STATUS (*check most appropriate*)

- ☐ No lost work time
- ☐ Return to work without restriction
- ☐ Return to work with modification
- ☐ Have not returned to work
- ☐ Not employed outside the home

Work days lost due to condition: _____days