PERRY PHYSICAL THERAPY, INC.

PATIENT REGISTRATION

Name _____ Date _____
Last First MI

Address _____
Street City State Zip Code

Phone *(w/area code)* _____ Work Phone _____ Cell Phone _____

Social Security Number _____ Birth Date _____ E-mail Address _____

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

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Caucasian ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined

Language: ☐ English ☐ Spanish ☐ Other _____

Employer _____ Occupation _____

Employer's Address _____ Your Primary Care Physician _____

Referring Physician _____ Date of your next visit _____

Name of person who should receive statement *(other than patient)* _____

Statement address *(if different than patient's address)* _____

Who should we contact in an emergency? _____ Phone Number _____

INSURANCE INFORMATION *(PLEASE GIVE YOUR CARDS TO RECEPTIONIST FOR COPYING)*

Primary Insurance _____

Insured's Name _____ Birth Date _____

ID Number _____ Group Number _____

Secondary Insurance _____

Insured'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 (location) _____

Involvement in Accident if Auto ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Cyclist

Attorney's *(Name/Address/Phone)* _____

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

Address _____ Phone Number _____

Claim Number _____ Adjuster _____ Name of Insured _____

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

☐ I was a Former Patient
☐ Doctor recommendation
☐ Insurance Company recommendation
☐ Health Club recommendation
☐ Clinic Sign
☐ TV advertisement
☐ Former Patient recommendation
☐ Family or Friend recommendation
☐ Employer recommendation
☐ Newspaper advertisement
☐ Billboard advertisement
☐ Radio advertisement
☐ Case Manager recommendation
☐ Yellow Page advertisement
☐ Web page

Name _____

Name _____

I learned about you another way. *(please explain)* _____

PATIENT SIGNATURE _____ Date _____

PERRY PHYSICAL THERAPY, INC.

PATIENT QUESTIONNAIRE / HEALTH HISTORY

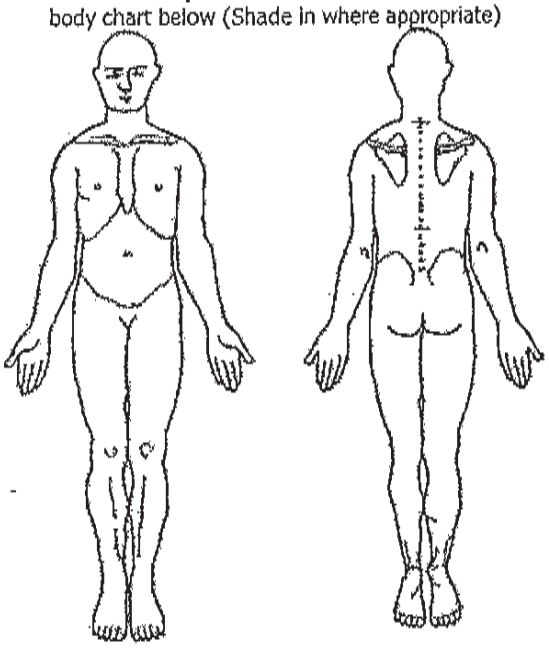
NAME: _____ DATE: _____

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 ☐ Average ☐ Poor
☐ Good ☐ Fair

Do you exercise outside of normal daily activities?
☐ 5+ days/wk ☐ 1-2 days/wk ☐ zero
☐ 3-4 days/wk ☐ occasionally
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

Patient Initial Questionnaire/Health History

Patient Signature_____

PERRY
PHYSICAL
THERAPY

HIPAA Privacy Policies/Release of Information

Perry Physical Therapy, Inc. releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in the HIPPA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits. I acknowledge I was offered a copy of Perry Physical Therapy's HIPAA Privacy Policies.

I do want to receive a copy of the privacy policy. _____
I do not want to receive a copy of the privacy policy._____

Perry Physical Therapy, Inc. requires a written request for copies of your medical records. We also require a written authorization by the patient or responsible adult to release medical records. There is a $25 fee for making copies and sending them to the requestor. This fee is paid by the requestor, but never the patient. We will try to expedite the processing of the request; however, we have 30 days to comply with any request for copies of your medical records.

Perry Physical Therapy, Inc. has permission to RELEASE or DISCUSS any medical information to the following. (Check any or all that you approve.)

My Spouse_____ My Parent_____ My Child_____Other_____

Perry Physical Therapy, Inc. has permission to leave a message on my answering machine/voicemail for the following reasons: (check any or all that you approve)

Appointment date and time or Missed Appointments_____ Billing Issues/Balance_____

Your Health Information Rights
You have certain rights under federal privacy standards. These include:
*The rights to request restrictions on the use and disclosure of your health information.
*The right to receive confidential communications concerning your medical condition and treatment.
*The right to inspect and copy your health information.
*The right to amend and/or submit corrections to your health information.
*The right to receive any accounting of how and to whom your health information had been disclosed.
*The right to receive any printed copy of this notice.

Complaints
If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you can contact the company by sending a letter outlining your concerns to:

Privacy Officer, Stacey Matthews
Perry Physical Therapy, Inc.
3737 Britton Rd.
Perry, MI 48872

Signature of Patient/Responsible Party or Guardian:_____
Printed Name:_____ Date:_____
Relationship of signor to patient, if signed by person other than patient:_____

PERRY
PHYSICAL
THERAPY

Informed Consent for Physical Therapy Evaluation and Treatment and Patient's Rights and Responsibilities

Patient Name _____

Please initial each section to indicate your understanding and agreement.

____Consent: I consent to and authorize Perry Physical Therapy, Inc. (including students in training) to administer physical therapy evaluation and treatment under the direction and supervision of the licensed physical therapist. The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation, and course of treament. The physical therapist has informed me of expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained the risks of receiving no treatment. I understand that I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually, but not always, temporary; if it does not subside within a reasonable time frame (1-2 days), I agree to immediately inform my physical therapist and discuss possible solutions with him/her. My physical therapist has explained that there is no guarantee that the proposed course of treatment will improve my condition or that my condition with not degenerate further; however, I should gain a greater knowledge about managing my condition and the resources available to me.

It is my right to decline any part of my treatment at any time before or during treatment, should I feel any pain or have any unresolved concerns. It is my right to ask the physical therapist about the treatment he/she has planned. Consequently, it is my right to discuss the potential risks and benefits involved in my treatment.

In order for physical therapy treatment to be effective, I must come to scheduled appointments, unless there are unusual circumstances. I understand and agree to cooperate with and perform the physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

In the event of a change in medical status, I understand that my treatment may be modified, stopped, or referred out to the proper practitioner. I agree to inform my physical therapist about any health problems or allergies I have, as well as medications I am taking.

I have been given an opportunity to ask questions, and all of my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form. I reserve the right to withdraw at any time. I understand the risks associated with a program of physical therapy as outlined to me, and I wish to proceed.

____24 hour Cancellation Policy: Please provide 24 hour notice in order to reschedule or cancel your appointment. Cancellations with less than 12 hours notice, or no notice, will result in an automatic $35 fee. If you arrive late for your appointment, the therapist may not have time to treat you, or your therapy time may be reduced.

Signature of Patient/Responsible Party or Guardian:_____
Printed Name:_____ Date: _____
Relationship of signor to patient, if signed by person other than patient:_____