Summit Physical Therapy

1425 Main Street, Follansbee, WV 26037 Phone: 304-527-4472 Fax: 304-527-4648

First Name: ________________________________ **MI:**______ **Last Name:** _________________________________

Nick Name: _____________ **SSN:** __ __ __ - __ __ - __ __ __ __ **Gender:** M /F **D.O.B.:** __ __ - __ __ - __ __ __ __

Marital Status: (Single/Married/Other/Widow/Divorced) ____

Patient Status: (Not Applicable/Employed/Full-time Student/Part-time Student) _____________________________

Address: ____ **City:** ____

State: __________ **Zip Code:** _________________ **Email:** ____

Home #: (_______)_________________ **Cell #:** (_______)_________________ **Work #:** (_______)_________________

Summit will send a reminder text/email of your next appointment. Please check the appropriate box.

☐ Email

☐ Text

Approximate Date of Injury/Reason for Physical Therapy: ____

____

Emergency Contact /Relationship: ___________________________________ **Phone #:** (_____) _________________

☐ This contact is permitted to discuss the medical conditions of the patient.

Family Physician: ____ **Phone #:** (_______)________________________

Referring Physician: _____________________________________ **Phone #:** (_______)________________________

Employer Name: ____ **Phone #:** (_______)________________________

Name of Insurance: ____

Subscriber's name/D.O.B.: ____

Subscriber's employer: ____

Are you receiving home care at the present time? ☐ Yes ☐ No

If yes, which home care company is providing the services? ____

If no, when were you discharged? ____

I hereby authorize **SUMMIT PHYSICAL THERAPY** to release any information concerning my case to the appropriate individuals or insurance companies. I hereby accept full responsibility for any amount not covered by my insurance. I authorize payment of medical benefits to **SUMMIT PHYSICAL THERAPY**. I understand an interest of 1.5% will be applied monthly to all overdue accounts and all monthly payments are a minimum of 25% of the balance.

TREATMENT CONSENT AUTHORIZATION: I am fully aware of my medical diagnosis and prognosis and consent to allow **SUMMIT PHYSICAL THERAPY** to provide treatment for my condition.

SIGNATURE: _________________________________ **PRINT NAME:** ______________________________________

DATE: _____________________ ☐ Yes, Summit Physical Therapy may leave messages on my phone.

Summit Physical Therapy - Outpatient Medical History

Name: ____ **Today's Date:** _________________

Existing or relevant previous conditions:

Allergies	□Yes □No	Dizzy Spells	□Yes □No	MRSA	□Yes □No
Anemia	□Yes □No	Emphysema/Bronchitis	□Yes □No	Multiple Sclerosis	□Yes □No
Anxiety	□Yes □No	Fibromyalgia	□Yes □No	Muscular Disease	□Yes □No
Arthritis	□Yes □No	Fractures	□Yes □No	Osteoporosis	□Yes □No
Asthma	□Yes □No	Gallbladder Problems	□Yes □No	Parkinson's	□Yes □No
Autoimmune Disorder	□Yes □No	Headaches	□Yes □No	Rheumatoid Arthritis	□Yes □No
Cancer	□Yes □No	Hearing Impairments	□Yes □No	Seizures	□Yes □No
Cardiac Conditions	□Yes □No	Hepatitis	□Yes □No	Smoking	□Yes □No
Cardiac Pacemaker	□Yes □No	High Cholesterol	□Yes □No	Speech Problems	□Yes □No
Chemical Dependency	□Yes □No	High/Low Blood Pressure	□Yes □No	Strokes	□Yes □No
Circulation Problems	□Yes □No	HIV/AIDS	□Yes □No	Thyroid Disease	□Yes □No
Currently Pregnant	□Yes □No	Incontinence	□Yes □No	Tuberculosis	□Yes □No
Depression	□Yes □No	Kidney Problems	□Yes □No	Vision Problems	□Yes □No
Diabetes	□Yes □No	Metal Implants	□Yes □No		

Describe any other conditions or precautions: ____

____

____

Fall History

Is your injury the result of a fall in the past year? □Yes □No Two or more falls in the past year? □Yes □No

Surgical History *(Please indicate at least the year surgery was performed)*

Body Region: ________________________ Surgery Type: _____________________________ Date: ___________

Body Region: ________________________ Surgery Type: _____________________________ Date: ___________

Body Region: ________________________ Surgery Type: _____________________________ Date: ___________

Body Region: ________________________ Surgery Type: _____________________________ Date: ___________

Current Medications:

Drug: __________________ Dosage: ____________ Frequency: ______________ Reason Taking: _____________

Drug: __________________ Dosage: ____________ Frequency:______________ Reason Taking: _____________

Drug: __________________ Dosage: ____________ Frequency:______________ Reason Taking: _____________

Drug: __________________ Dosage: ____________ Frequency:______________ Reason Taking: _____________

□ Currently not taking any medications

Are you allergic to any medications? □Yes □No If yes, please list____

____

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Place an X in the box if any of these diagnostic tests have ever been performed.

	Test	***Date***	***Results***
	X-Rays		
	MRI		
	CAT scan		
	EMG/NCV		
	Bone scan		

Description of problem: ____

Was it due to an injury? □Yes □No If yes, what was the date and how did it happen? ____________________

____

Was it a gradual onset? □Yes □No If yes, when did it begin? __________________________________

____

Is the problem work-related? □Yes □No If yes, please explain how it is related? ____________________

____

Were you involved in a motor vehicle accident? □Yes □No If yes, please describe. ____________________

____

Is litigation (law suit) involved? □Yes □No If yes, who is your attorney? ___________________________

Have you ever had any previous injuries involving the same area? □Yes □No If yes, please describe the injury and approximate date(s). ____

Do you smoke? □Yes □No If yes, how much? _________________ Are you pregnant? □Yes □No

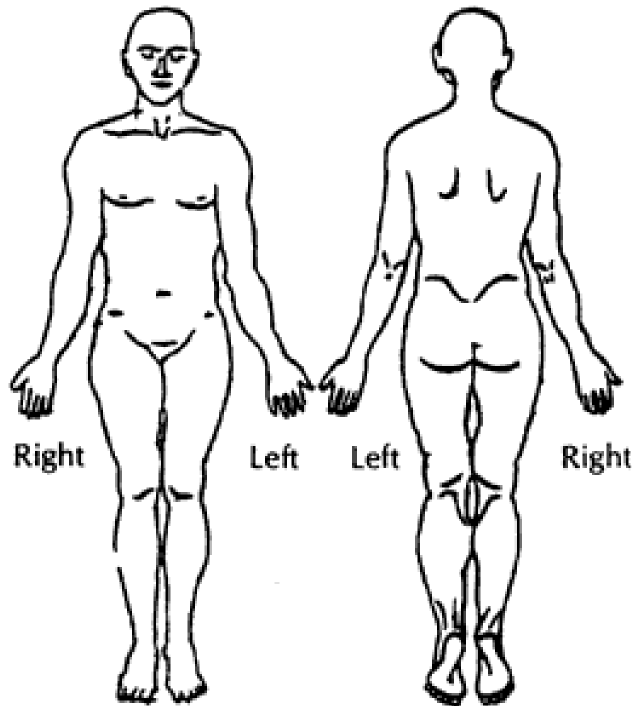
I, the undersigned, state that I have answered the questionnaire to the best of my knowledge.

Signature ______________________________________ Date ____________________________

Summit Physical Therapy - Pain Diagram Form

Please use the diagram below to indicate where you feel symptoms right now. Use the key to indicate how the symptoms feel.

KEY
Pins and Needles = OOOOOO Stabbing = ///////// Burning = XXXXXXX Deep Ache = ZZZZZZZZ



1. What is your pain level right NOW on a scale from 0 (no pain) to 10 (extreme pain)? _______________
2. What has been your WORST pain level in the last 24 hours on a scale from 0 to 10? ________________
3. What has been your BEST pain level in the last 24 hours on a scale from 0 to 10? __________________

Place an X in the box(es) that best describe your pain.

	Constant		Increasing		Night Pain		Dull/achy pain
	Intermittent		Decreasing		Stiffness		Pain upon walking
	Occasional		Static		Sharp pain		After standing or walking too long
Pain is aggravated by:							
Pain is eased by:							

1. Have you been treated by a physical therapist? □Yes □No
2. Have you been treated by a chiropractor? □Yes □No
3. What were you treated for? ____

Summit Physical Therapy

Acknowledgement of Receipt of Notice of Privacy Practices

Last Name: ______________________ First Name: ___________________ MI: _____ DOB: ________

In general, any information you receive about your health care, or payment for the care, is considered confidential and protected by our practice. We may need to use your protected health information to carry out treatment, payment health care operations and/or other purposes. Our notice of privacy practices provides a more complete description of permitted uses and disclosures.

I acknowledge that I have received a copy of the Notice of Privacy Practices.

______________________________	______________________________
Please print patient's full name	Date
______________________________	______________________________
Signature of patient or patient representative	Relation

Consent and Release

1. I am consenting to examination and treatment by physicians and allied health professionals employed by Summit Physical Therapy. I understand I will not be involved in research or experimental procedures without my knowledge or consent.

2. I am responsible for paying for all services provided to me, which may include collection fees, and agree any insurance benefits for my account will be paid directly to Summit Physical Therapy. I authorize Summit Physical Therapy to submit insurance claims on my behalf. I certify all information given by me in applying for payment by any third party is true and accurate.

3. I authorize release of my medical bills to the person whose medical insurance is paying all or part of my account.

4. I understand I may receive separate bills for professional interpretation and/or for hospital outpatient services.

5. I authorize Summit Physical Therapy to submit Medicare claims on my behalf and request payment of authorized Medicare benefits be made directly to Summit Physical Therapy for any services provided. Additionally, I authorize release of any medical information regarding my care in order to determine potential payable services.

I authorize Summit Physical Therapy to disclose my personal health information to the following individual(s) who are involved in my care:

____________________	____________________	____________________
Printed Name of Individual	Relationship to Patient	Telephone Number
____________________	____________________	____________________
Printed Name of Individual	Relationship to Patient	Telephone Number

I have been given the opportunity to ask questions about this document. By signing below, I declare that I understand the above information:

______________________________	______________________________
Signature of Patient or Representative	Date