

# Summit Physical Therapy

621 N Chester Street, New Cumberland, WV 26047 Phone: 304-564-1098 Fax: 304-564-5020

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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: \_\_\_\_\_

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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

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Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Existing or relevant previous conditions:**

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

\_\_\_\_\_

# Summit Physical Therapy - Outpatient Medical History – pg. 2

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

|  | <i>Test</i>      | <i>Date</i> | <i>Results</i> |
|--|------------------|-------------|----------------|
|  | <b>X-Rays</b>    |             |                |
|  | <b>MRI</b>       |             |                |
|  | <b>CAT scan</b>  |             |                |
|  | <b>EMG/NCV</b>   |             |                |
|  | <b>Bone scan</b> |             |                |

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.**

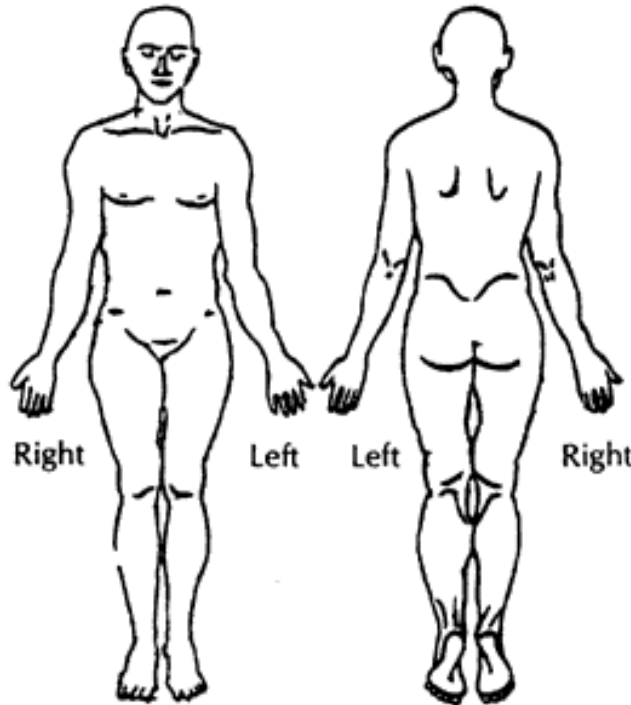
Signature \_\_\_\_\_ Date \_\_\_\_\_

# 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 = XXXXXXXX    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.**

|                                       |                                     |                                     |   |
|---------------------------------------|-------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Constant     | <input type="checkbox"/> Increasing | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Dull/achy pain                     |
| <input type="checkbox"/> Intermittent | <input type="checkbox"/> Decreasing | <input type="checkbox"/> Stiffness  | <input type="checkbox"/> Pain upon walking                  |
| <input type="checkbox"/> Occasional   | <input type="checkbox"/> Static     | <input type="checkbox"/> Sharp pain | <input type="checkbox"/> 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