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: (S/M/D/W) **Patient Status: (NA / Employed / Full-time Student / Part-time Student)**

Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Home #: (_____)_____ **Cell #:** (_____)_____ **Work #:** (_____)_____

Appointment Reminder: □ Email □ Text **Preferred method of other communication:** Phone / Email / Text / Mail

Summit Physical Therapy may leave messages on my phone? □Yes □No

How were you referred to Summit PT: Summit Website / Physician / Insurance / Friend / Former Patient

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Emergency Contact & Relationship: _____ Phone #: (_____) _____

This emergency contact is permitted to discuss the medical conditions of the patient. □Yes □No

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Family/Referring Physician: _____ Phone #: (_____)_____

Employer Name: _____ Phone #: (_____)_____

Name of Insurance: _____

Subscriber's Name/D.O.B.: _____

Subscriber's Employer: _____

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: _____

Summit Physical Therapy - Outpatient Medical History

Today's Date: _____ Name: _____ Height: _____ Weight: _____

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 medical precautions: _____

_____

FALL HISTORY

Are you at risk for a fall? □Yes □No **How many falls have you had in the past year?** None / One / Two

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: *(Dosage must be included)*

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 List any medication allergies: _____

_____

Summit Physical Therapy - Outpatient Medical History (cont.)

DIAGNOSTIC TESTS

X-Rays: □Yes □No **MRI:** □Yes □No **CAT Scan:** □Yes □No **EMG/NCV:** □Yes □No **Bone Scan:** □Yes □No

_____	_____	_____	_____	_____
(Date)	*(Date)*	*(Date)*	*(Date)*	*(Date)*

Approximate date of injury: _____

Description of problem for which you are seeking physical therapy: _____

_____

_____

Are you receiving home care now? □Yes □No **If yes, home care company name? _____**

If no, when were you discharged? _____

Have you received any physical therapy or chiropractic care this year? □Yes □No

If yes, what were you treated for? _____

Was it due to an injury? □Yes □No **Was it a gradual onset?** □Yes □No

Is the problem work-related? □Yes □No **Were you involved in a motor vehicle accident?** □Yes □No

Is litigation (lawsuit) involved? □Yes □No **If yes, who is your attorney? _____**

Have you ever had any previous injuries involving the same area? □Yes □No

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

Signature _____ Date _____

PAIN DIAGRAM FORM

On the diagram below, use the **KEY** to indicate the type of pain you're feeling and where. Record your pain level using the **PAIN SCALE**.

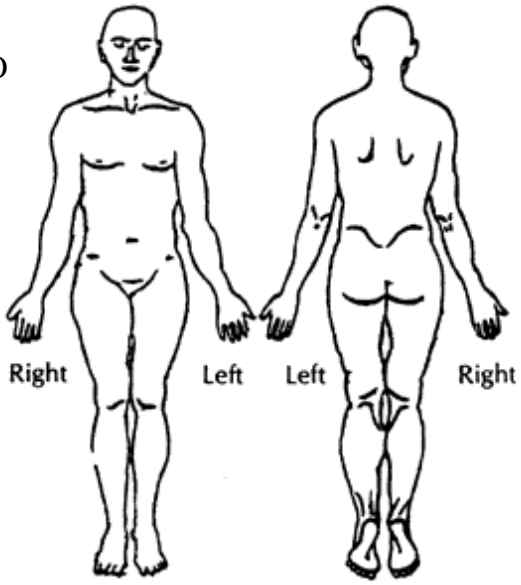
KEY

Pins and Needles = OOOOOO

Stabbing = /////////

Burning = XXXXXXX

Deep Ache = ZZZZZZZZ



PAIN SCALE

0 = No Pain through **10 = Extreme Pain**

Current pain level now: _____

Worst pain level in last 24 hours: _____

Best Pain level in last 24 hours: _____

Place a √ 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: _____

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

Signature _____ Date _____

Summit Physical Therapy

Acknowledgement of Receipt of Notice of Privacy Practices

First Name: _____ MI: _____ Last Name: _____ 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 physical therapists 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 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