

# Summit Physical Therapy

414 Penco Road, Weirton, WV 26062 Phone: 304-723-3780 Fax: 304-723-4110

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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

Emergency Contact & Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

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

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

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Today's Date: \_\_\_\_\_ Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## **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 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: \_\_\_\_\_

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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.)

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## **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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
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Are you receiving home care now? Yes No If yes, home care company name? \_\_\_\_\_

If no, when were you discharged? \_\_\_\_\_

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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 \_\_\_\_\_

# Summit Physical Therapy

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## 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**.

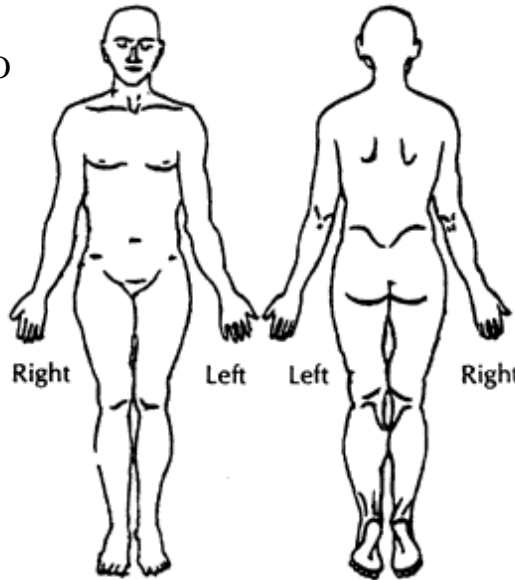
### KEY

Pins and Needles = OOOOOO

Stabbing = //////////////

Burning = XXXXXXXX

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  $\surd$  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: \_\_\_\_\_

**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