Redwood Orthopaedic Physical Therapy
Patient Information Record Date: _____

Name: _____ DOB: _____ Age: _____

Occupation: _____

Did this injury occur at work? Yes/No if yes, date of injury: _____

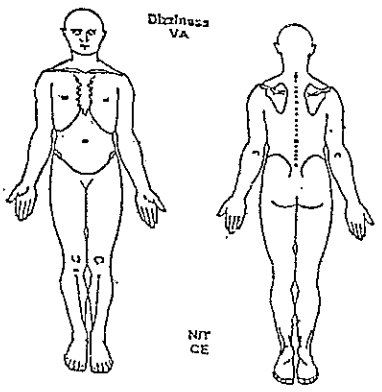
Are you off of work due to your problem? Yes/No

Recreational Activities: _____

Are you currently limiting your recreational activities? Yes/no

Please answer the following questions as accurately as possible. Check, circle yes/no or fill in blanks as needed.

1. Draw where your symptoms/problems are on the body chart:



2. Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10
   Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

3. Date of onset of present pain/problem(s): _____

4. What caused your pain to begin (describe accident or injury) _____

_____

5. For this injury, has your care included surgery? Yes/No Date: _____ Type: _____

6. What activities make your pain worse? _____

7. What eases your pain? _____

8. Does your pain wake you at night? Yes/No Can you get back to sleep easily? Yes/No

9. How do you feel in the morning? Stiff_____ Painful_____ Fine_____ Other_____

10. How do you feel at the end of the day? Better_____ Same_____ Worse_____ Other_____

11. Have you had this problem/pain before? If so, when? _____

12. Have you had any of the following tests/Interventions:

X-rays: Yes/No Date: _____ EMG: Yes/No Date: _____ MRI/CT Scan: Yes/No Date: _____

Injection: Yes/No Date: _____ and did it help? Yes/No

13. Have you taken steroids or blood thinners? Yes/No When? _____

14. Have you EVER been diagnosed as having any of the following conditions?

Yes/No	Diabetes	Yes/No	Depression
Yes/No	High Blood Pressure	Yes/No	Bleeding Disorder
Yes/No	Heart Condition	Yes/No	Cancer
Yes/No	Tuberculosis	Yes/No	Seizures/Epilepsy
Yes/No	Asthma	Yes/No	Hepatitis
Yes/No	Dizziness	Yes/No	Stomach Ulcers
Yes/No	Loss of balance/Clumsy Walking	Yes/No	Kidney disease
Yes/No	Difficulty with bowel movement	Yes/No	Head Trauma
Yes/No	Change in ability to pass urine	Yes/No	Headaches
Yes/No	Osteoporosis	Yes/No	Stroke
Yes/No	Rheumatoid Arthritis/Osteoarthritis	Yes/No	Pregnancy (currently)

Do you smoke? Yes/No How many per day? _____

Have you fallen more than 1 time in the past year? Yes/No

Have you fallen and hurt yourself in the past year? Yes/No

Please list any surgeries in the past 10 Years: _____

_____

Have you RECENTLY experienced any of the following?

Yes/No	weight loss/gain	Yes/No	nausea/vomiting
Yes/No	fatigue	Yes/No	weakness
Yes/No	fever/chills/sweats	Yes/No	numbness or tingling

15. Are you willing to make exercise a daily component of your lifestyle to manage your problem(s)? Yes/No

What is a reasonable amount of time for you exercise program per day? _____

16. List the goals you hope to achieve from physical therapy treatment: _____

_____

Thank You for taking the time to fill out this information sheet. **Please** feel free to ask questions pertaining to your condition during your examination of treatment.

Clinic Name

CURRENT MEDICATIONS LIST REPORT

PATIENT NAME:

DATE:

LIST ALL THE PRESCRIPTION MEDICATIONS YOUR ARE CURRENTLY TAKING			
NAME OF THE MEDICATION	DOSAGE (how many or how much you take)	FREQUENCY (how often do you take it)	ROUTE (how do you take it, i.e., by mouth, injection etc.)

LIST ALL OVER-THE -COUNTER MEDICATIONS			
NAME OF THE MEDICATION	DOSAGE (how many or how much you take)	FREQUENCY (how often do you take it)	ROUTE (how do you take it, i.e., by mouth, injection etc.)

LIST ALL HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS			
NAME OF THE MEDICATION	DOSAGE (how many or how much you take)	FREQUENCY (how often do you take it)	ROUTE (how do you take it, i.e., by mouth, injection etc.)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, PRN Physical Therapy creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among PRN Physical Therapy personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and treatment to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for PRN Physical Therapy that provides a more complete review of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices before signing this consent.

I understand that PRN Physical Therapy may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand PRN Physical Therapy for **Worker's Compensation Cases**, will release the minimum necessary PHI/ePHI to my employer, my worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that PRN Physical Therapy is not required to agree to the restrictions requested. The procedure to request **restriction** on information use and disclosure is contained in the Notice of Privacy Practices. Please complete the following that apply.

[__] I **DO NOT** authorize release of my information with the following individuals or organizations (enter names below and initial the box to left):

[__] I **DO** authorize sharing of my information with the following individuals or organizations (enter names below and initial the box to left):

[_____] Spouse/Children:_____

[_____] Other: _____

These restrictions and/or authorizations to release information will remain in effect until terminated in writing.

Appointment Communication Preference: I prefer to be contacted in the following manner:

[__] Home Phone [__] Work Phone [__] My Mobile Phone [__] Email

Provide email address or phone number:_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of PRN Physical Therapy and that the full version is posted at my treatment facility and available upon request. I agree to the liability limitations explained therein.

_____ _____ _____

Signature of patient or legal representative Date Relationship to Patient

_____

Printed name of patient

Redwood Physical Therapy

Consent and Statement of Financial Responsibility

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times give one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $25 depending on appointment type.

   WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

3. **RESPONSIBILITY FOR PAYMENT:** All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Redwood Physical Therapy, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Redwood Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

   Please note that refusal to sign this form does not change responsibility for payment in any way.

4. **ASSIGNMENT OF BENEFITS:** I hereby assign to Redwood Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. **MEDICARE PATIENTS**: Have you received any prior physical therapy this year? (circle) YES NO Have you received any home healthcare services this year? (circle) YES NO

6. **CONSENT FOR EMERGENCY CONTACT INFORMATION**

   Person to contact in case of an emergency:

   _____ _____ _____
   Name Telephone Number Relationship:

   By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

   _____ _____
   Signature of Patient or Legally Responsible Person Date

   _____ _____
   Printed Name of above Date