

# WELCOME TO ADVANCE PHYSICAL THERAPY

*Please take a few moments to complete this form in its entirety. All information will be considered confidential, and will be released only as allowed through HIPAA regulations, and as considered necessary for treatment, payment, or other health care operations.*

## PATIENT INFORMATION

**LAST Name** \_\_\_\_\_ **FIRST Name** \_\_\_\_\_ **MI** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**City** \_\_\_\_\_ **State** \_\_\_\_\_ **ZIP** \_\_\_\_\_  
**Home Phone** \_\_\_\_\_ **Work #** \_\_\_\_\_ **Cell #** \_\_\_\_\_  
**Date of Birth** \_\_\_\_\_ **SSN** \_\_\_\_\_ **Sex**  M  F  
**Emergency Contact** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Phone** \_\_\_\_\_  
**Area of Injury/Pain** \_\_\_\_\_ **Date of Injury** \_\_\_\_\_  
**Marital Status (check one)**  Minor  Single  Married  Divorced  Widowed  Separated  
**Employer** \_\_\_\_\_ **Work Phone** \_\_\_\_\_  
**Employer Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Accident Related?**  Yes  No **Type**  Auto  Work  Other  
**How did you hear about our office?**  Physician  Former Patient  Phone Book  Other  
**Referring Physician** \_\_\_\_\_ **Primary Care Physician** \_\_\_\_\_  
**Work Comp Case Worker** \_\_\_\_\_ **Phone** \_\_\_\_\_  
**Lawyer (if applicable)** \_\_\_\_\_ **Phone** \_\_\_\_\_

## RESPONSIBLE PARTY/GUARANTOR INFORMATION

**Name of person responsible for this account** \_\_\_\_\_  
**Relationship to patient** \_\_\_\_\_ **Daytime Phone** \_\_\_\_\_ **Home Phone** \_\_\_\_\_  
**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Employer** \_\_\_\_\_ **Employer Phone** \_\_\_\_\_

## INSURANCE INFORMATION

<b>Primary Insurance Carrier</b> _____ <b>Insured Name</b> _____ <b>Relationship to Patient</b> _____ <b>Policy/ID#</b> _____ <b>Group #</b> _____ <b>Insured Date of Birth</b> _____ <b>Insured SSN</b> _____ <b>Insured's Employer</b> _____	<b>Secondary Insurance Carrier</b> _____ <b>Insured Name</b> _____ <b>Relationship to Patient</b> _____ <b>Policy/ID#</b> _____ <b>Group #</b> _____ <b>Insured Date of Birth</b> _____ <b>Insured SSN</b> _____ <b>Insured's Employer</b> _____
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## CONSENT TO TREAT/ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION

*I hereby consent to evaluation and treatment by authorized personnel of APT as may be dictated by prudent medical practice for my (or my child's) illness, injury or condition. I authorize APT to bill the insurance carrier(s) or other third party payor named above and authorize assignment of benefits directly to APT. I also authorize release of medical information for the purposes of treatment, payment, or other health care operation for my case. (Refer to APT Billing Policy Statement).*

**PATIENT/RESPONSIBLE PARTY SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

*Office Use Only*

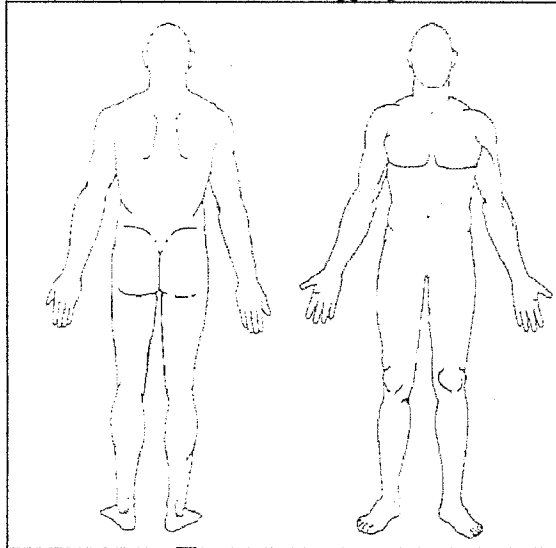
<b>PATIENT</b> _____	<b>ACCOUNT#</b> _____	<b>SOC DATE</b> _____
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**TO ENSURE YOU RECEIVE A COMPLETE AND THOROUGH EVALUATION, PLEASE PROVIDE US WITH IMPORTANT INFORMATION ON THIS FORM. IF YOU DO NOT UNDERSTAND THE QUESTION, PLEASE ASK FOR ASSISTANCE. THANK YOU.**

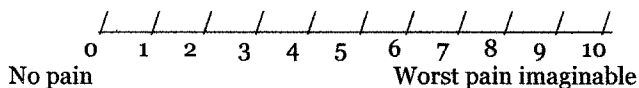
**HISTORY OF PRESENT CONDITION**

1. What are your symptoms? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Localize areas of pain or abnormal sensation on the body chart below (shade where appropriate)



2. Please indicate on the scale below the worst your pain has been in the last 24 hours.



3. When did your symptoms begin? \_\_\_\_\_  
 (Please indicate a specific date if possible.) If surgery or accident, please indicate date \_\_\_\_\_

4. Which of the following best describes how your injury occurred? (If your condition is post surgical, please indicate as per your original injury.)

- lifting       degenerative process       unknown
- car accident       recreation/sports       trauma
- a fall       running       overuse
- throwing       unknown
- other \_\_\_\_\_

5. Since onset, have your symptoms:  
 improved       worsened       not changed

6. Have you had similar symptoms in the past?  yes  no  
 More than one episode?  yes  no

7. Check all that apply to describe the nature of your symptoms.

- burning       sharp       occasional
- dull       aching       constant
- throbbing       tingling       periodic
- numb       stabbing       cramping
- other \_\_\_\_\_

8. As the day progresses, do your symptoms:  
 worsen       improve       remain the same

9. Does the pain disturb your sleep?  
 often       sometimes       never

10. Do you have pain or stiff ness when getting out of bed in the morning?  yes  no

11. In what position do you sleep?  
 right side       left side       stomach  
 back       back/sides/stomach       chair/recliner

12. What aggravates your symptoms?

- sitting       standing       up/down stairs
- walking       sleeping       sitting to standing
- squatting       stress       standing to sitting
- coughing/sneezing       reaching across body
- reaching overhead       reaching behind back
- taking a deep breath       reaching in front of body
- bending       looking overhead
- household activities       recreational activities
- other \_\_\_\_\_

13. What relieves your symptoms?

- heat       sitting       standing
- cold/ice       rest       stretching
- walking       medication       massage
- exercise       lying down       nothing
- other \_\_\_\_\_



**PATIENT QUESTIONNAIRE/HEALTH HISTORY**

Name \_\_\_\_\_  
 Date \_\_\_\_\_ Ref MD \_\_\_\_\_

14. Check previous treatments you have had for this condition.

- none       hypnosis       oral medication
- exercise       TENS unit       biofeedback
- traction       casting       bracing/taping
- bed rest       acupuncture       spinal injection
- manipulation       skin/muscle injection
- physical therapy       hospitalization

15. Check any of the following diagnostic tests that you have had performed for this current condition.

- none       x-ray       bone scan
- MRI       CT       arthrogram
- stress x-ray test (telos)       blood work
- other \_\_\_\_\_

16. What are your goals from physical therapy?

\_\_\_\_\_

17. Do you have a specific time frame in mind for reaching these goals?     yes     no

How long? \_\_\_\_\_  days     weeks     months

18. In order to get better, you will be expected to participate in your treatment. This may include doing exercises (here and/or at home) or avoiding certain activities. How committed are you to participating in your treatment?

- very       somewhat       not very

### **MEDICATION**

Please list any prescription medications that you are currently taking (pain pills, injection, skin patches, etc.) Attach a separate sheet if necessary \_\_\_\_\_

\_\_\_\_\_

List any over the counter medications that you are currently taking \_\_\_\_\_

\_\_\_\_\_

List any allergies to food, medications or topical agents: \_\_\_\_\_

\_\_\_\_\_

### **WORK HISTORY**

**Occupation** \_\_\_\_\_

- employed full time       employed part time
- self employed       homemaker
- student       retired       unemployed

Does this condition affect your work status in any way?

- yes     no

**Physical activities at work** (check all that apply)

- sitting       standing       phone use
- heavy lifting       driving       repetitive bending
- computer use       heavy equipment operation
- other \_\_\_\_\_

Are you currently receiving or seeking disability for this condition?     yes     no

If not performing your normal activities at work, do you plan to return to your previous activity level?     yes     no

### **LIVING SITUATION**

- live alone       multi-level
- assisted living complex       live with family members/others
- live with caregiver       other \_\_\_\_\_

### **GENERAL HEALTH**

How would you rate your general health?

- excellent       average       poor

Do you exercise outside of normal daily activities?     no

- 5+ days/week     1-3 days/week     occasionally

Exercise, sports/recreation consisting of \_\_\_\_\_

Do you drink caffeinated beverages?     yes     no

Do you smoke?     yes     no    *packs per day* \_\_\_\_\_

What is your stress level?     low     medium     high

Are you, or could you be, pregnant?     yes     no

### **PAST MEDICAL/PAST FAMILY HISTORY**

Have you (P) or an immediate family member (F) ever been diagnosed with any of the following conditions?  
(Check/circle all that apply)

- cancer    **P F** (type) \_\_\_\_\_
- heart problems    **P F**       depression    **P F**
- stroke    **P F**       allergies    **P F**
- diabetes    **P F**       arthritis    **P F**
- kidney problems    **P F**       osteoporosis    **P F**
- thyroid problems    **P F**       epilepsy/seizures    **P F**
- circulatory problems    **P F**       Parkinson's    **P F**
- high blood pressure    **P F**       headaches    **P F**

List any surgeries you have had related to your current problem.

\_\_\_\_\_

**PATIENT** \_\_\_\_\_

**SOC** \_\_\_\_\_ **REF MD** \_\_\_\_\_

**ADVANCE PHYSICAL THERAPY**

**SYSTEMS REVIEW**

Since onset of this current condition, have you experienced any of the following symptoms (either new or aggravation of chronic problem)? Check all that apply.

- General**  fever  chills  weight changes  fainting  appetite changes  lethargy  sleep changes  fatigue
- Ears, nose, mouth, throat**  pain  nose bleeds  sores  noise sensitivity  ringing in ears
- Cardiovascular**  chest pain  shortness of breath  irregular pulse  hypertension  numbness of extremities
- Respiratory**  wheezing  asthma  shortness of breath  cough
- Gastrointestinal**  nausea  vomiting  heartburn  painful bowels  diarrhea  constipation  abdominal pain
- Genitourinary**  urinary pain  urinary frequency  burning on urination  sexual difficulty  incontinence
- Eyes**  pain  spots  twitching  blurred vision
- Musculoskeletal**  joint pain  muscle pain  muscle cramps  fractures  swelling  arthritis  weakness
- Neurological**  dizziness  tremors  lack of coordination/balance  tension  headaches  numbness/tingling
- Integumentary (skin)**  rashes  sores  scars  pain  masses/lumps
- Endocrine**  sweating  voice changes  thirst
- Psychiatric**  depression  anxiety  emotional instability  memory loss
- Hematologic/Lymphatic**  bruising  fatigue  enlarged glands  phlebitis  anemia
- Allergic/Immunologic**  allergies to medications \_\_\_\_\_

<b>FUNCTIONAL BASELINE</b>						
<i>Please circle the level of difficulty you have TODAY for each of the activities listed below.</i>	<b>Able to do without any difficulty</b>	<b>Able to do with little difficulty</b>	<b>Able to do with moderate difficulty</b>	<b>Able to do but with much difficulty</b>	<b>Unable to do</b>	<b>Not applicable</b>
Lying flat	1	2	3	4	5	9
Rolling over	1	2	3	4	5	9
Lying to sitting	1	2	3	4	5	9
Sitting	1	2	3	4	5	9
Sitting to standing	1	2	3	4	5	9
Standing to sitting	1	2	3	4	5	9
Squatting	1	2	3	4	5	9
Bending/stooping	1	2	3	4	5	9
Balancing	1	2	3	4	5	9
Kneeling	1	2	3	4	5	9
Walking-short distance	1	2	3	4	5	9
Walking- long distance	1	2	3	4	5	9
Climbing stairs	1	2	3	4	5	9
Going down stairs	1	2	3	4	5	9
Walking outdoors	1	2	3	4	5	9
Hopping	1	2	3	4	5	9
Jumping	1	2	3	4	5	9
Running	1	2	3	4	5	9
Pushing	1	2	3	4	5	9
Pulling	1	2	3	4	5	9
Reaching out front	1	2	3	4	5	9
Reaching overhead	1	2	3	4	5	9
Reaching back	1	2	3	4	5	9
Grasping	1	2	3	4	5	9
Lifting	1	2	3	4	5	9
Carrying	1	2	3	4	5	9
Personal care (washing,dressing)	1	2	3	4	5	9
Driving	1	2	3	4	5	9

**PATIENT** \_\_\_\_\_ **SOC** \_\_\_\_\_ **REF MD** \_\_\_\_\_

**ADVANCE PHYSICAL THERAPY**