PHYSICAL THERAPY SOLUTIONS
1198 FRONT ST., TONGANOXIE, KS 66086 PHONE 913-417-7400 FAX 913-369-2836

NEW PATIENT INFORMATION

PLEASE PRINT

NAME_____ **AGE**_____ **SEX**_____ **DATE**_____

ADDRESS_____ **CITY, STATE**_____ **ZIP**_____

PHONE NUMBER (HOME)_____ **(CELL)**_____ **(WORK)**_____

E-MAIL_____ **BIRTHDATE**_____ **SOCIAL SECURITY #**_____

PRIMARY DOCTOR_____ **PHONE NUMBER**_____

REFERRING DOCTOR _____ **PHONE NUMBER** _____

EMPLOYER & ADDRESS_____

WORK STATUS ☐ Employed ☐ Off Work ☐ Unemployed ☐ **RETIRED** ☐ **DISABLED**

EMERGENCY CONTACT NAME & PHONE #_____

INSURANCE CARRIER(S)_____ **POLICY HOLDER: (CIRCLE ONE) SELF SPOUSE PARENT**

(IF NOT YOURSELF) NAME:_____ **SEX:**_____ **DOB:**_____

STREET ADDRESS:_____ **CITY/STATE/ZIP:**_____

SOCIAL SECURITY #:_____ **EMPLOYER:**_____

IS YOUR CONDITION RELATED TO AN AUTO ACCIDENT OR WORK INJURY?_____ **DATE OF INJURY**_____

BRIEFLY DESCRIBE YOUR CHIEF COMPLAINT OR SYMPTOMS._____

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical record.

Welcome to Physical Therapy Solutions. This Facility is required by law to abide by the terms of this Health Care Privacy Consent as well as other applicable federal and state laws governing privacy practices in health care. Photocopy of this Consent is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to the licensed professionals of this Facility. Our Facility, Providers & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our facility. At the front desk of this office is a HIPAA Privacy Notice that describes how medical information about you may be used and disclosed and how you can obtain access to this information. You are welcome to read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility. Our Facility may use & disclose your PHI for health care delivery purposes only. Your PHI may be used and/or disclosed without your written authorization by the providers and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your providers and the staff will take all reasonable measures to maintain the confidentiality of your PHI.
Our facility is committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery.

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice. I am also disclosing pertinent, truthful and comprehensive information on these forms and to my provider(s).

Signature_____ Date_____

Updated Information_____ Date_____

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MEDICAL HISTORY

NAME_____ TODAY'S DATE_____

DATE OF INJURY &/OR SURGERY?_____ DATE SYMPTOMS STARTED_____

HOW DID YOU HURT YOURSELF?_____

PAIN FREQUENCY: ☐CONSTANT ☐FREQUENT ☐INTERMITTENT ☐NIGHT ONLY ☐OTHER?_____

DESCRIBE YOUR PAIN: ☐SHARP ☐SHOOTING ☐STABBING ☐ACHING ☐NUMBNESS ☐TINGLING ☐BURNING ☐WEAKNESS

ARE YOUR SYMPTOMS: ☐GETTING WORSE ☐THE SAME ☐IMPROVING PAIN RATED (0-10):_____

IS YOUR PAIN: ☐BETTER IN THE MORNING, WORSE LATER ☐WORST IN THE MORNING, EASES AFTER TIME ☐AT NIGHT ONLY

WHAT AGGRAVATES YOUR PAIN: ☐STANDING ☐SITTING ☐LYING ☐BENDING ☐TWISTING ☐WALKING ☐LOOKING UP

☐OTHER?_____

WHAT RELIEVES YOUR PAIN: ☐STANDING ☐SITTING ☐LYING ☐BENDING ☐TWISTING ☐WALKING ☐OTHER?_____

WHAT DOES YOUR PAIN PREVENT YOU FROM DOING: ☐EXERCISE ☐DRESSING ☐SHOPPING ☐COOKING ☐SITTING

☐PERSONAL HYGIENE ☐STANDING ☐WORK ☐LIFTING ☐OTHER?_____

HOW ARE YOU ABLE TO SLEEP AT NIGHT: ☐WITHOUT DIFFICULTY/FINE ☐MODERATE DIFFICULTY ☐ONLY WITH MEDICATION

CHECK ALL OF THE ITEMS THAT YOU HAVE BEEN DIAGNOSED WITH OR TREATED FOR IN THE PAST:

☐ARTHRITIS (CIRCLE) RA OA	☐FIBROMYALGIA	☐HEART PROBLEMS	☐OSTEOPOROSIS
☐HEADACHES	☐CANCER	☐DEFIBRILLATOR/PACEMAKER	☐ASTHMA
☐NECK PAIN	☐CHEST CONGESTION	☐DEVELOPMENTAL PROBLEMS	☐PARKINSONS DISEASE
☐BACK PAIN	☐HIV/AIDS	☐HIGH BLOOD PRESSURE	☐SEIZURES
☐BROKEN BONES	☐COPD	☐INFECTIOUS DISEASE	☐STROKE/TIA
☐DIABETES	☐DEPRESSION	☐LUNG PROBLEMS	☐ABDOMINAL ANEURISM
	☐MULTIPLE SCLEROSIS	☐BRONCHITIS	☐CIRCULATORY/ VASCULAR PROBLEMS

☐LIST ALLERGIES _____

ARE YOU CURRENTLY PREGNANT?	YES	NO
ARE YOU CURRENTLY UNDER STRESS?	YES	NO
DO YOU OR HAVE YOU USED TOBACCO?	YES	NO
DO YOU DRINK ALCOHOLIC BEVERAGES?	YES	NO
DO YOU HAVE ANY HARDWARE IN YOUR NECK OR BACK?	YES	NO
DO YOU HAVE A DEFIBRILLATOR, PACEMAKER OR NEUROSTIMULATOR?	YES	NO
ARE YOU SEEING ANY OTHER HEALTH CARE PROVIDER FOR YOUR SYMPTOM(S)?	YES	NO

HAVE YOU TRIED ANY OF THE FOLLOWING METHODS TO TREAT YOUR SYMPTOM(S):

PHYSICAL THERAPY	YES	NO
CHIROPRACTIC	YES	NO
EPIDURALS	YES	NO
SURGERY	YES	NO
LONG-TERM STEROID USE	YES	NO
PAIN MEDICATION	YES	NO
OTHER DOCTORS	YES	NO
TENS UNIT	YES	NO
BRACE/ORTHOTIC	YES	NO

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PLEASE LIST ALL SURGERIES OR ACCIDENTS (WITH DATES):_____

_____

_____

_____

CURRENT MEDICATIONS (PRESCRIPTION & OVER –THE-COUNTER) WE CAN TAKE A COPY OF YOUR LIST:_____

_____

_____

_____

WHAT DO YOU HOPE TO ACHIEVE BY ATTENDING PHYSICAL THERAPY:

_____

_____

_____

_____

FOR MEDICARE PATIENTS ONLY (Please circle yes or no to each question below)

Y N Are you currently or have you been treated by a physical, occupational, or speech therapist this calendar year?

Y N Is your illness due to work related accident/condition and is it being covered by work comp?

Y N Is your illness or injury covered under automobile insurance, no fault insurance, medical payments coverage, personal injury insurance, liability insurance, or a medical "set aside" account from a legal settlement?

Y N Are you being treated by for an injury/illness for which another party could be liable?

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file insurance claims for you including Medicare, medigap, and other health insurance companies.
2. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
3. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.
4. For your convenience we accept most major credit & debit cards.

INFORMED CONSENT

I understand that this Facility, its providers & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However, as with any examination, health history, or diagnostic test findings, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of physical therapy there are some risks including but not limited to fractures, disk injuries, dislocations, sprains-strains and/or other injuries or side effects that cannot be pre-determined. I do not expect the provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the provider to exercise judgment during the course of the procedure(s) which the provider feels at the time is in my best interest. In addition, because psychosocial, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you. Therefore, I give my full consent to the provider of this Facility to render treatment on me or the minor for whom I am legally responsible.

SIGNATURE_____ DATE_____

UPDATED INFORMATION_____ DATE_____