

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A Complete medical history is necessary for a through evaluation. Please answer the following questions

Your Name:				Today's Date:
Date of Birth:	Age:	Height:	Weight:	Do you Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female If female, are you currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 1 st Trimester <input type="checkbox"/> 2 nd Trimester <input type="checkbox"/> 3 rd Trimester				

Have you ever been diagnosed with any of the following?

Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Condition	<input type="checkbox"/> No <input type="checkbox"/> Yes	Epilepsy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Respiratory Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Metal in Body	<input type="checkbox"/> No <input type="checkbox"/> Yes	Pacemaker	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other _____	<input type="checkbox"/> No <input type="checkbox"/> Yes		

Who referred you to physical therapy? _____ **Primary Physical** _____

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates): _____ **Recent flare-ups?** No Yes **If yes, when?** _____

What activities are limited by this condition? (e.g. lift, reach) _____

How did your injury/symptoms occur? _____

What do you expect to accomplish with physical therapy? _____

Are your symptoms Constant? Intermittent? Getting Better?
 Getting worse? Staying the same

What makes your symptoms better? _____

0-10 pain scale (0= No Pain; 10= The most extreme pain)
Worst pain rating; _____ Best pain rating; _____

For this injury, has your medical care included: (check those that apply)

Surgery: When? ___/___/___ What Kind? _____ Injection: When? ___/___/___

Did it help? Yes No

Other treatment:

Physical therapy If yes, when? ___/___/___ to ___/___/___
What was done? _____

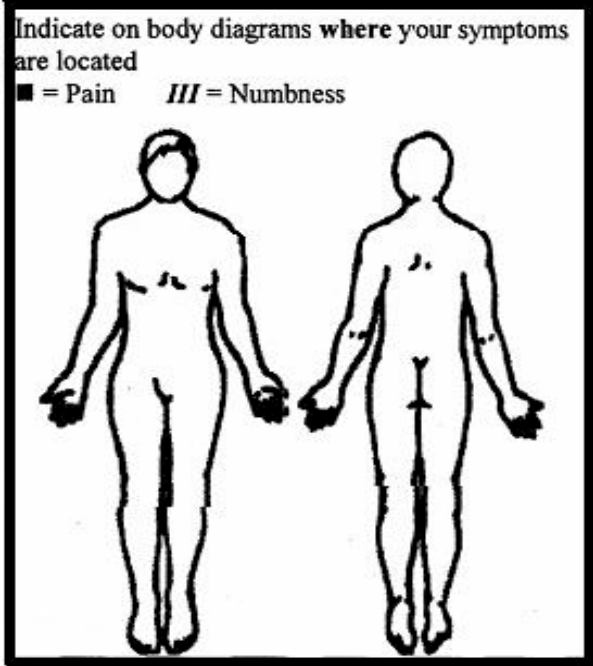
Chiropractor If yes, when? ___/___/___ to ___/___/___
What was done? _____

Medications: _____

X-ray _____ MRI _____

CT scan _____ Other: _____

Exercises: What kind? _____
Problems? No Yes _____



Comments: _____

Work Information

Who is your employer? _____ what is your job title/responsibilities? _____

Are you currently working? No Yes If yes, numbers of hours per week _____ Full Duty Restricted Duty

How many total work days have you missed? _____ Do you have a case manager/QRC? No Yes

Your Therapist Will Complete This Section

Critical Work, ADL, or leisure activities affected: _____

Lift/Carry: ≤20 lbs. Rarely to occasionally (low demand) ≥20 lbs., or ≥1lbs. constantly or ≥ 10 lbs frequently (mod-high demand) Where to Where _____ to _____

Repetitive motions related to condition: Occasional 1-33% (low demand) Frequent to Constant 34-100% (mod-high demand)

Static positions related to condition (mod-high): Sit Stand Crouch Kneel Overhead work

Leisure Activities: None/minimally impact condition (low demand) Moderate-high intensity, competitive (mod-high demand)

Overall functional demand (work/ADL/leisure) Low Demand Moderate-High Demand

UPPER BODY AND NECK		LOWER BODY AND LOW BACK	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Drinking or eating _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Getting in and out of <input type="checkbox"/> chairs, <input type="checkbox"/> bed, <input type="checkbox"/> car, <input type="checkbox"/> bath or shower _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Getting in and out of <input type="checkbox"/> chairs, <input type="checkbox"/> bed, <input type="checkbox"/> car _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Balancing on one or both feet _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Putting on/taking off shoes, shirts, jackets _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sitting _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep through the night _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Driving a vehicle _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Reaching: <input type="checkbox"/> overhead, <input type="checkbox"/> behind back, <input type="checkbox"/> downward <input type="checkbox"/> forward _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Standing _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Ability to sit _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ability to use foot controls (accelerator or brake in vehicle) _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Maintaining static position of <input type="checkbox"/> head forward bent, <input type="checkbox"/> arms overhead, <input type="checkbox"/> arms forward, <input type="checkbox"/> turning head to check traffic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dressing: putting on/taking off shoes, socks, shirts, pants, or jacket _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Picking up small objects _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep through the night _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Gripping, holding tools, opening jars _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Walking on: <input type="checkbox"/> flat surfaces, <input type="checkbox"/> inclines or uneven surfaces, <input type="checkbox"/> stairs or ladders _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Lifting or carrying _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Running/recreation _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Housework/yard work (i.e., vacuum, mop, scrub, dust, sweep) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bending _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Ability to care for children or dependent adult _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kneeling _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational activities _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Squatting _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Job activities _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lifting or carrying _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Housework/yard work (i.e., laundry, sweeping, vacuuming) _____
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;">Your Therapist will complete this section</div>		<input type="checkbox"/> Yes <input type="checkbox"/> No	Ability to care for children or dependent adult _____
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Perform overhead activities _____
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Job activities _____
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____

Knee

- Swelling: Immediate (1st hour) Delayed Increasing Decreasing None
- Does patient's knee: "Lock"? "Buckle"? Keep cap shift? Not applicable
- Scheduled for surgery? No Yes
If yes, when? _____

Back

- % of pain in Back _____% Leg _____%
- Bowel/Bladder dysfunction No Yes _____
- Cough/Sneeze aggravates symptoms? No Yes _____

Neck

- % of pain in Neck _____% Arm _____%
- Sleep on stomach? No Yes
- Jaw or dental problems? No Yes
Describe _____
- Headaches? No Yes Location _____ Freq.&Dur _____

All

0-10 pain scale (0=No Pain; 10= The Most Extreme Pain)
 Worst pain this far: _____ Best pain rating this far: _____ Typical pain thus far: _____ Today's pain rating: _____
 Comments: _____

SPINAL/JOINT MOBILIZATION INFORMED CONSENT

The information below is to inform you regarding a treatment technique commonly preformed in physical therapy. If you agree to this treatment, please sign your name and date the bottom of this form. E&L Associates Physical Therapy thanks you for you cooperation.

1. Question: What in mobilization?

Answer: It is a hands on procedure carried out to correct soft tissue or boney problems

2. Spinal or joint mobilization can produce the following benefits –

- a. Correct the position of a spinal or joint segment, thus increasing joint mobility**
- b. Decrease pain symptoms**

3. Spinal or joint mobilization cannot be done if a patient

- a. Is taking anticoagulant medication**
- b. Has a broken bone in the area of a mobilization that is not healed (6 weeks)**

4. Which health care professionals can do mobilization procedures?

- 1. Chiropractors**
- 2. Orthopedic Physical Therapists**
- 3. Doctors of Osteopathy and Medical Doctors**

5. What are other appropriate treatment options besides mobilization?

- 1. Modalities including heat, ultra sound and electrical stimulation**
- 2. Soft tissue mobilization and Myofascial release techniques**
- 3. Exercises**

I agree to this treatment

Patient's signature and date

Therapist signature and date

PATIENT CONSENT TO TREAT

I hereby authorize and grant permission to **E&L Associates Physical Therapy**, to carry out any assessment and examination, procedure and treatments as may be necessary to access and treat my condition or injury.

The above – named physical therapist group and staff has agreed to provide me with understandable information on:

- My diagnosis as known
- The treatment being suggested
- Significant risks, benefits or treatment, and possible alternative to this treatment
- Reasonable additional procedures which may be necessary
- The potential risk(s) of foregoing suggested care

I hereby authorize and grant permission to **E&L Associated Physical Therapy** to release information regarding my condition and my ability to return to normal activity or work to my insurance company employer lawyer or their representative (please check those that apply). I also hereby authorize and grant **PRN** a billing and collections company/ representative for **E&L Associates Physical Therapy** permission to release information regarding my condition to my insurance company employer lawyer or their representative (please check those that apply).

I, _____ understand the conditions and information as verbally provided and voluntarily give my consent to the above authorizations.

Date

signature

witnessed by



FINANCE POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

It is important that you understand that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

If your Workers Compensation carrier has approved physical therapy services, fees for approved services under Workers Compensation are established by the state. Payment for those services is the responsibility of your Workers Compensation carrier and not you. Should your Workers Compensation carrier not approve any or all of the physical therapy services, and you choose to have those services despite that fact, payment for those services would be your responsibility and would be due at the time services are rendered unless payment agreements exist and have been approved in advance by our staff. We accept cash, checks, MasterCard, or Visa. Please be advised that there will be a \$25.00 service charge added to your account for any returned checks.

If you are unable to keep your appointment, please call in advance so that someone else may see the therapist in the time which had been reserved for you. There will be a \$40.00 charge added to your account for all no show appointments.

Should the account be referred for collection, the undersigned shall pay reasonable collection expenses including attorney's fees.

If you have any questions regarding the above information or regarding payment, please do not hesitate to ask us. We are here to help. The undersigned certifies that h/she has been informed and has read the foregoing and is the patient, patient's parent or guardian, or is duly authorized by the patient's general agent, and that he/she accepts the terms contained in this finance policy.

SIGNATURE _____ DATE _____



REMINDER!!!

****REGARDING NO-SHOWS AND CANCELLATIONS****

We would like to remind you of E&L Physical Therapy's policy on late cancellations (cancellations without at least 12 hours notice) and 'no shows' (missed appointments without a call to cancel or reschedule).

We may charge a fee of \$40.00 for any appointment that is cancelled without at least 12 hours notice and for any no shows.

This fee is due directly from the patient and is payable at the time of the next scheduled appointment.

As a matter of policy, your referring physician, and claims adjuster if applicable, are notified each time an appointment is missed for any reason.

REMINDER!!

****REGARDING DISCHARGE DUE TO MISSED APPOINTMENTS****

It is E&L Physical Therapy's policy that *after a patient no shows or cancels their appointments for three (3) consecutive scheduled visits they are automatically discharged* from the program and must return to their physician to obtain a new prescription or referral for physical therapy before resuming care. Physician, Adjuster, and Case Manager will be notified as well.

Out of consideration for staff and fellow patients, as well as consistency in your rehabilitation, please contact our office immediately if you are unable to attend your scheduled visits.

Thank You

Patient Signature

Date

3.5.1C PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

E&L ASSOCIATES PHYSICAL THERAPY

(Clinic Name)

I have read and understand the HIPPA Protected Health Information Privacy Notice
3.5.1A. I understand that upon request a copy of the complete notice will be
provided to me.

Patient Name (Print)

Patient Signature

Date