THE CENTRAL ORTHOPEDIC GROUP PHYSICAL THERAPY

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE
PLEASE ANSWER ALL QUESTIONS

PATIENT INFORMATION

EMAIL _____

First Name: Last Name: M.I.

Address: City: State: Zip:

Birth Date / / Age: Male ☐ Female ☐ S.S.# Marital Status

Home Phone: Alternate Phone(s):

Chose facility because/Referred to facility by ☐ Dr: ☐ Insurance Plan ☐ Family _____

☐ Friend _____ ☐ Former Patient ☐ Close to Work/Home ☐ Street Sign ☐ Yellowbook

☐ Website _____ ☐ Other _____

WORK INFORMATION

Employer: Work Phone ( ) Ext

Occupation: Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

CARE PROVIDER INFORMATION

Referring Dr: Referring Dr. Phone: ( )

Medical Dr./PCP: Medical Dr./PCP Phone: ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Carrier:

Subscriber Name: Birth Date: / /

I.D.#: Group/Policy #:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Carrier:

Subscriber Name: Birth Date: / /

I.D.#: Group/Policy #:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: ☐ Auto: ☐ Work/Labor: ☐ Claim #

Adjuster/Claim Rep: Phone: ( ) Ext

Address: City: State: Zip:

ATTORNEY INFORMATION

Name: Law Firm: Phone: ( )

Address: City: State: Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative:

Relationship to Patient: Home Phone: ( ) Alt. Phone: ( )

PAST MEDICAL HISTORY FORM			Patient Name_____		
MUSCLE CONDITION	**☐YES**	**☐NO**	**OTHER CONDITIONS**	**☐YES**	**☐NO**
Carpel Tunnel R/L	☐	☐	Muscular Dystrophy	☐	☐
Tennis Elbow	☐	☐	Rheumatoid Arthritis	☐	☐
Back/Neck Problems	☐	☐	Multiple Sclerosis	☐	☐
Limited Limb Movement	☐	☐	Epilepsy	☐	☐
JOINT CONDITION	☐	☐	Gout	☐	☐
Upper Extremity	☐	☐	Fibromyalgia	☐	☐
Dislocation	☐	☐	Diabetes/Low Blood Sugar	☐	☐
Lower Extremity Dislocation	☐	☐	Hearing Loss	☐	☐
BLOOD PRESSURE	☐	☐	Poor Eye Sight	☐	☐
Hypertension	☐	☐	Fainting	☐	☐
Low Blood Pressure	☐	☐	Atherosclerotic Disease	☐	☐
Normal Blood Pressure	☐	☐	Asthma	☐	☐
HEART DISEASE	☐	☐	Emphysema	☐	☐
Pacemaker	☐	☐	Shortness of Breath	☐	☐
Heart Attack	☐	☐	Other: _____		
Myocardial Infarction	☐	☐	_____		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS
☐ None	☐ Sitting	☐ Low	☐ Smoking Packs/Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol Drinks a wk ___
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda Cups a wk ___
☐ 5+ x Week	☐ Heavy Labor		

What types of exercise do you perform? _____
Stress causing conditions? _____

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy? ☐YES ☐NO If yes list name(s): _____

List all medications you are currently taking: _____

List all surgeries in the past(including dates): _____

Are you pregnant? ☐YES ☐NO If yes, what week? _____

Have you had any injuries related to work or any auto accidents?☐YES ☐NO If yes list body part & date: _____

Have you had Physical Therapy or Massage Therapy before☐YES ☐NO Where? _____

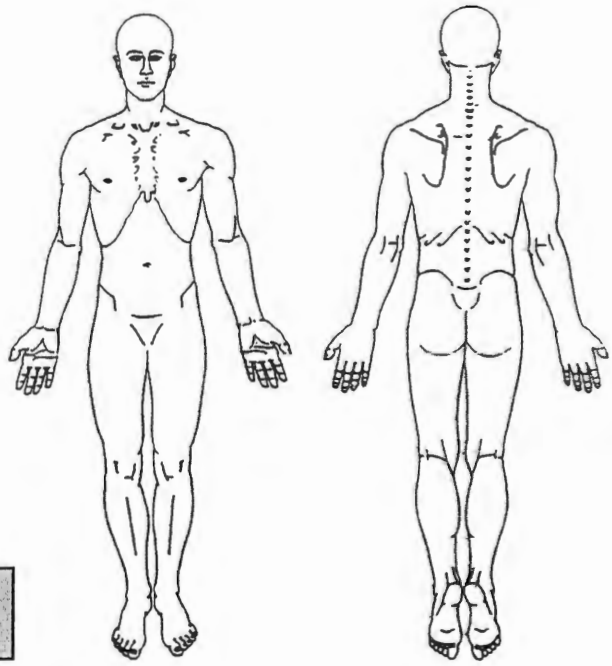
_____ _____

Signature of Patient, Parent, Guardian, Personal Representative **Date**

PAIN AND SYMPTOM STATUS REPORT

Name: _____ Date _____

Using the symbols below, please draw at the location the type of pain you are experiencing.



Ache	Burning	Numbness
MMM	-- -- -- --	O O O O
M	-- --	O O O

Pins and Needles	Stabbing	Other
□□□□□□	///////	x x x x
□□□□	/////	x x x

CHIEF COMPLAINT AND VISUAL ANALOG SCALE

My Chief Complaint is: _____

Date First Symptom of your problem occurred on _____

2nd Complaint _____

3rd Complaint _____

Please Circle on the scale below to indicate your <u>CURRENT</u> level of pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 HIGHEST LEVEL OF PAIN

Please Circle on the scale below to indicate your <u>AVERAGE</u> level of pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 HIGHEST LEVEL OF PAIN

Please Circle on the scale below to indicate your <u>WORST</u> level of pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 HIGHEST LEVEL OF PAIN

Additional Comments _____

_____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Central Orthopedic Group Physical Therapy to furnish medical care and treatment necessary in diagnosing or treating his/her physical condition.

_____ _____

Signature of Patient/ Guardian **Date**

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign medical benefits to which I am entitled, including Medicare, private insurance and third party payers to Central Orthopedic Group Physical Therapy. A photocopy of this assignment is information necessary including Medical records, to secure payment.

_____ _____

Signature of Patient/ Guardian **Date**

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I, hereby authorize Central Orthopedic Group Physical Therapy to obtain any and all medical records concerning my care from any physician, hospital or health care professional that has provided medical care to me in the past.

I also authorize Central Orthopedic Group Physical Therapy practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself/and or any child at anytime.

_____ _____

Signature of Patient/ Guardian **Date**

ACKNOWLEDGEMENT FORM

I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Policy Notice", which describes the Practice's obligations to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care options. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask any questions about it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.

I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future and that I can receive a copy of the Practice's current Privacy Notice at anytime.

I understand that I have the right to request that the Practice restrict its uses and disclosures of my health information for treatment, payment and health care operations. If my restrictions are accepted by the Practice, these restrictions will be binding on the Practice. I also understand that the Practice is not required to agree to my requested restrictions.

I do not request any restrictions on the Practice's uses and disclosures of my health information for treatment, payment or health care operations. _____ (Initial)

By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at anytime in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance of this consent.

_____ _____

Signature of Patient/ Guardian **Date**

[ ] Patient chose not to sign acknowledgement
Reason: _____

_____

Office staff acknowledging patients refusal to sign consent

THE CENTRAL ORTHOPEDIC GROUP, LLP

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DATE OF EXAM:_____Account number#_____

PATIENT NAME: _____
Responsible Party/ Policy Holder : _____
Insurance Company name: _____ Member Id#_____

How did the occurance happen?

_____
_____
_____

What part of the body was injured/hurt?

_____
_____

Date of Onset: _____

Address of Onset: _____

Was this related to a Motor Vehicle accident yes / no

Was this a Work related accident yes / no

I affirm that the above statement is true and request the release of any monies from my insurance company to the Central Orthopedic Group, LLC.

I also give permission to the Central Orthopedic Group to release any information necessary to pay this claim to my health insurance company.

PATIENT SIGNATURE:_____ Date: _____

Responsible party Signature:_____Date: _____