



Today's Date: _____ Referring Physician: _____

Patient Name: _____ Preferred or nickname: _____
 (Last) (First) (MI)

Home Address _____

City: _____ State: _____ Zip: _____

Home Phone # _____ Cell Phone # _____

SSN: _____

Date of Birth: _____ Age: _____ Sex: ___ Male ___ Female

Email Address: _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed

Patient's Employer: _____ Occupation: _____

Business Phone: _____

Spouse's Name: _____ Employer: _____

Occupation: _____ Business Phone: _____

Emergency Notification (other than spouse): _____ Phone Number: _____

How did you hear about us: Friend/Family Web Phone Book Facebook Other _____

How would you like to be contacted for Appointment Reminders: Home Phone Cell Phone Text Message

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Insurance Information

Workers Compensation:

Insurance Name: _____ Adjustor: _____

Phone Number: _____ Date of Injury: _____ Claim #: _____

Attorney Name: _____ Attorney Phone Number: _____

Private Insurance:

Primary Insurance Company: _____ Address: _____

Phone Number: _____ Group/Company Name: _____

Group #: _____ Insured's Name: _____

DOB: _____ SSN#: _____ ID#: _____

Patient relationship to insured: ___ Self ___ Spouse ___ Child ___ Other

Secondary Insurance Company: _____ Address: _____

Phone Number: _____ Group/Company Name: _____

Group #: _____ Insured's Name: _____

DOB: _____ SSN#: _____ ID#: _____

Patient relationship to insured: ___ Self ___ Spouse ___ Child ___ Other

Private Pay:

I will be responsible to pay for services at the time they are rendered.



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Physical Therapy Financial Policy:

Insurance plans sometimes have limits or maximum allowed charges on Physical Therapy and services. There may be limits on the number of visits the insurance company will cover per year and/or per injury. Know your plan benefits, you are responsible for payment regardless of your insurance benefits. If your plan does have limits or maximums you will be expected to pay at the time of service when you reach these limits. You need to be aware if you have had any previous physical therapy or chiropractic treatments as insurance companies sometimes consider these as the same type of care and will count towards the total visits for benefits. If you have any questions as to your coverage for these services call your insurance company.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES REGARDLESS FOR MY INSURANCE BENEFITS.

I hereby authorize release of information to my employer, physician, attorney, and insurance company. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Patient's Signature: _____ Date: _____



Ardmore Physical Therapy Inc. - Medical Screening Questionnaire

Name: _____ Date of Birth: _____ Date: _____
 Occupation: _____ Height: _____ Weight: _____ Gender: M F

Do you have a pacemaker: **Yes/No**, Do you smoke? **Yes/No**, Are you latex sensitive? **Yes /No**
 Are you currently receiving home health for any reason? **Yes/No** If so, please List: _____
 WOMEN: Are you currently pregnant or do you think you might be pregnant: **Yes/No**

Current Symptoms

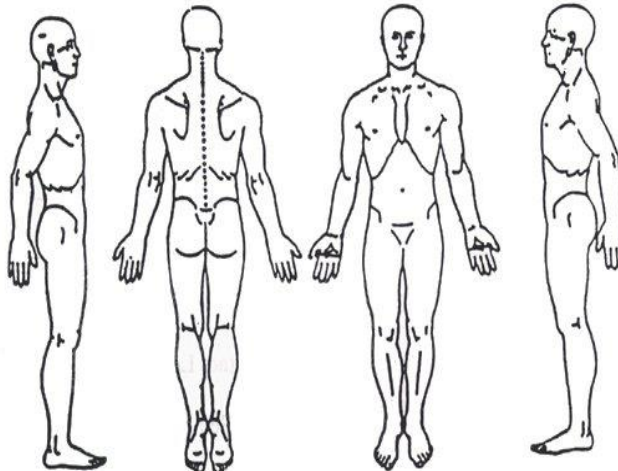
Where are you currently having symptoms? _____
 What date (approx) did your symptoms start? _____ How did your symptoms start? __ Gradual __ Suddenly __ Injury
 Currently working? **Yes/No** Last day worked _____
 What do you think caused your symptoms? _____
 My symptoms are currently: __ Getting Better __ Getting Worse __ Staying about the same

Treatment received so far for this problem (injections, chiropractic, etc): _____
 Have you had any diagnostics tests (please circle):
 x-ray MRI CT scan EMG/NCV Bone Density Lab Work Other/Results _____

Have you ever had this problem before: Yes / No, When _____ If so, how treated? _____
 Did you get better and how long did it take _____

I should not do physical activities that might make my pain worse: __ Disagree __ Unsure __ Agree

Body Chart: Please mark the areas where you feel symptoms on the chart to your right with the following symbols:
Shooting/sharp pain (↓), Dull/aching pain (o ×), Numbness (≡), Tingling (ooo)



My symptoms currently: __ Come and go __ Are constant __ Are constant, but change with activity

When are your symptoms worst?: __ Morning, __ Afternoon, __ Evening, __ Night, __ After Exercise

When are your symptoms the best?: __ Morning, __ Afternoon, __ Evening, __ Night, __ After Exercise

How are you currently able to sleep at night due to your symptoms? __ No Problems Sleeping __ Awakened by Pain
 __ Difficulty Falling Asleep __ Sleep only with Medication __ Other _____

Please circle the activities which make your pain worse:

Lying down / Bending/ Standing / Walking / Lifting / Twisting / Turning in Bed / Sitting / Overhead / Stress

Aggravating/Easing Factors: Any other positions or activities that make your symptoms worse(-) or better(+)?:

- Does coughing, sneezing or taking a deep breath aggravate your symptoms? **Yes / No**
- Does bending, sitting, lifting or twisting your back aggravate your symptoms? **Yes / No**
- Has there been any change in bowel habit since onset of your symptoms? **Yes / No**
- Does eating certain foods aggravate your symptoms? **Yes / No**
- Has there been any weight change since onset of symptoms? **Yes / No**

Using the 0-10 pain scale, please describe:

	0 = "no pain"					to	10 = "worst pain imaginable"				
Your current level of pain while completing this survey:	0	1	2	3	4	5	6	7	8	9	10
The best your pain has been the past 24 hours:	0	1	2	3	4	5	6	7	8	9	10
The worst your pain has been the past 24 hours:	0	1	2	3	4	5	6	7	8	9	10

Medical History

Have you RECENTLY (past 6 months) noted any of the following (circle all that apply)?

- | | | |
|------------------------------------|---|-------------------------|
| Fatigue | Numbness or Tingling | Headaches |
| Fever/chills/sweats | Muscle Weakness | Food Intolerances |
| Nausea/Vomiting | Dizziness / Lightheadedness | Change in Appetite |
| Heartburn / Indigestion | Poor Balance / Falls / Dizziness | Weight Loss/Gain |
| Shortness of Breath | Changes in Bowel / Bladder Function | Difficulty Swallowing |
| Leg Cramps When Walking | Changes in Urine/Stool Color | Fainting |
| Increased Pain at Night / Rest | Numbness in area that covers bicycle seat | Cough |
| Morning Stiffness lasting > 1 hour | Changes in Vision _____ | Difficulty Talking |
| Recent travel _____ | Recent infection/illness? _____ | Changes in Hearing ____ |
| | | Pain with menstruation |

Do you have now or have you EVER been diagnosed with any of the following (circle all that apply)?

- | | | |
|-------------------------|---|-------------------------|
| Diabetes I or II | Chemical Dependency (ie., Alcoholism) | Loss of Consciousness |
| Cancer-site _____ | Depression | Thyroid Problems |
| Heart Disease | Lung Problems/COPD/Bronchitis/Pneumonia | Parkinsons |
| Chest Pain / Angina | Tuberculosis | Osteoporosis |
| High Blood Pressure | Asthma | Multiple Sclerosis |
| Circulation Problems | Sexually Transmitted Disease / HIV | Epilepsy / Seizures |
| Blood Clots | Pelvic Inflammatory Disease | Eye Problem / Infection |
| Stroke | Endometriosis | Anemia |
| Strains / Sprains _____ | Bladder / Urinary Tract Infection | Ulcers |
| Metal implants _____ | Kidney Problem / Infection | Liver Problems |
| Bone / Joint Infection | Rheumatoid Arthritis | Hepatitis / Type _____ |
| Osteoarthritis _____ | Auto Immune Disease _____ | |
| Fractures-site _____ | Fibromyalgia | |

Has anyone in your immediate family (parents, brothers, sisters, children) EVER been diagnosed with any of the following conditions (circle all that apply)?

- | | | |
|---------------------|------------|------------------|
| Cancer | Diabetes | Tuberculosis |
| Heart Problems | Stroke | Thyroid Problems |
| High Blood Pressure | Depression | Blood Clots |

Please list (or provide a list that we may copy) of any surgeries & dates; any conditions for hospitalization & dates:

1. _____ 2. _____ 3. _____

Medications

Please list any prescribed medications (types of medication such as muscle relaxants) you are currently taking (INCLUDING pills, injections, skin patches, topicals) – if you have a list, may we copy it?

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

ALLERGIES: List any medications(s) you are allergic to: _____

Have you ever taken any steroid medications for any medical conditions: **Yes / No**

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **Yes / No**

Please list any Over-The-Counter medications you are currently using:

__ Advil/IB __ Antacids __ Aspirin __ Antihistamines __ Decongestants __ Laxatives __ Tylenol __ Vitamins __ Other

Personal / Goals:

During the past month have you been feeling down, depressed or hopeless? **Yes / No**

During the past month have you been bothered by having little interest or pleasure in doing things? **Yes / No**

Is this something with which you would like help? **Yes/ Yes, But Not Today/ No**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **Yes / No**

We are very interested in helping you get back to the work and hobby/leisure activities that you normally are able to do. Please identify up to three important activities that you are currently unable to do are or having difficulty with:

- 1. _____
- 2. _____
- 3. _____

Please circle the number below which best represents your overall average level of function.

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 **Able to do everything**

Please list personal goal(s) for physical therapy: _____

Is there anything else you would like to include or ask your physical therapist? _____

Patient Signature: _____ Date: _____

Physical Therapist Signature: _____ Date: _____

Cardiac /Screening Intake:

Temp:

BP:

HR:

Resp:

O2 sat:

BMI:



PRIVACY NOTICE ACKNOWLEDGMENT FOR THE OFFICE OF:

Ardmore Physical Therapy

This office takes the confidentiality of your medical information very seriously. We are providing privacy notices which make you aware of what the office can and cannot do with your protected health information (PHI). Please acknowledge receipt of the privacy notice by signing and dating this letter in the space provided below.

If you have any questions regarding this matter, please contact the chief privacy officer:

Contact Privacy Officer: Julie Keys Address: PO Box 1686
Telephone: 580-223-1925 Ardmore, OK 73401

Thank you for entrusting your health care to Ardmore Physical Therapy.
I acknowledge receipt of the Privacy Notice.

Signature

Date

Patient or legal representative refused to sign.

Employee signature/initials

Date

Cancellation and No Show Policy

You are coming to physical therapy to remedy the condition that is affecting you; therefore it is absolutely necessary that you attend all of your scheduled appointments. All missed appointments MUST be made up the same week so you may fully recover. Ardmore Physical Therapy requires 24 hour advance notice for any cancellation. If you are unable to give 24 hour advance notice or you do not show for your scheduled appointment an administrative fee of \$25.00 will be billed to you. Two cancellations or no show appointments will result in only being able to same day schedule once cancellation fees have been paid. I have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

Patient Signature

Date