ARDMORE
PHYSICAL THERAPY
COMMITTED TO EXCELLENCE IN PATIENT CARE

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**

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:**_____

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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

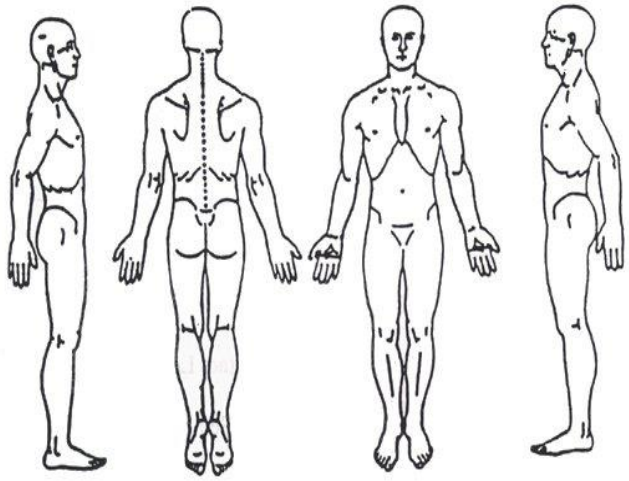
Where are you currently having symptoms? _____
What date (approx) did your symptoms start? _____ How did your symptoms start? __Gradual __Suddenly __Injury
Currently working? **Yes/No** Last day worked_____
What do you think caused your symptoms? _____
My symptoms are currently: __ Getting Better __ 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
Fever/chills/sweats
Nausea/Vomiting
Heartburn / Indigestion
Shortness of Breath
Leg Cramps When Walking
Increased Pain at Night / Rest
Morning Stiffness lasting > 1 hour
Recent travel_____
Numbness or Tingling
Muscle Weakness
Dizziness / Lightheadedness
Poor Balance / Falls / Dizziness
Changes in Bowel / Bladder Function
Changes in Urine/Stool Color
Numbness in area that covers bicycle seat
Changes in Vision _____
Recent infection/illness? _____
Headaches
Food Intolerances
Change in Appetite
Weight Loss/Gain
Difficulty Swallowing
Fainting
Cough
Difficulty Talking
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
Cancer-site_____
Heart Disease
Chest Pain / Angina
High Blood Pressure
Circulation Problems
Blood Clots
Stroke
Strains / Sprains _____
Metal implants _____
Bone / Joint Infection
Osteoarthritis_____
Fractures-site_____
Chemical Dependency (ie., Alcoholism)
Depression
Lung Problems/COPD/Bronchitis/Pneumonia
Tuberculosis
Asthma
Sexually Transmitted Disease / HIV
Pelvic Inflammatory Disease
Endometriosis
Bladder / Urinary Tract Infection
Kidney Problem / Infection
Rheumatoid Arthritis
Auto Immune Disease _____
Fibromyalgia
Loss of Consciousness
Thyroid Problems
Parkinsons
Osteoporosis
Multiple Sclerosis
Epilepsy / Seizures
Eye Problem / Infection
Anemia
Ulcers
Liver Problems
Hepatitis / Type _____

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

Cancer
Heart Problems
High Blood Pressure
Diabetes
Stroke
Depression
Tuberculosis
Thyroid Problems
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: