# Patient Information Form

-Please Print-

PATIENT NAME_____ DATE OF BIRTH_____

ADDRESS_____CITY_____SATE_____ZIP_____

PHONE (  )_____-_____ EMAIL: _____ SEX: M F AGE: _____

IS IT OKAY TO LEAVE A MESSAGE ON THE PHONE NUMBER YOU PROVIDED? YES NO

HOW DID YOU HEAR OF US? _____

REFERRING PHYSICIAN _____ PHYSICIAN'S PHONE (  )_____ - _____

EMERGENCY CONTACT_____ RELATIONSHIP _____

EMERGENCY CONTACT'S PHONE (  ) _____-_____

PRIMARY INSURANCE_____

SECONDARY INSURANCE_____

DO YOU NEED A TRANSLATOR? YES NO Would you like one provided? Yes No WHICH LANGUAGE: _____

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM PATIENT)

FULL NAME_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER NAME_____ EMPLOYER PHONE # _____

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HAVE YOU HAD PREVIOUS PHYSICAL THERAPY, OCCUPATIONAL THERAPY, OR SPEECH THERAPY THIS CALENDAR YEAR? YES NO HAVE YOU HAD HOME HEALTH THERAPY? IF SO, WHEN? _____

DO YOU HAVE AN ADVANCED DIRECTIVE? YES NO DO YOU NEED INFORMATION ON ONE? YES NO

PLEASE CHECK THE CAUSE OF INJURY RELATED TO THIS APPOINTMENT (MUST PICK ONE)

☐ AUTO ☐ WORK ☐ HOME ☐ OTHER (PLEASE EXPLAIN)_____

IF YOU CHECKED AUTO OR WORK ABOVE, PLEASE COMPLETE THE FOLLOWING:

IS THERE LEGAL ACTION PENDING? YES NO

ATTORNEY'S NAME _____ PHONE NUMBER _____

WORKER'S COMPENSATION CARRIER _____ CLAIM NUMBER _____

NAME OF ADJUSTER _____ PHONE (  ) _____-_____

HUNTINGTON BEACH
PHYSICAL THERAPY
SPECIALISTS

(714) 841-6162
www.HBPTS.com

# History and Physical Condition Information

Name: _____ Age:_____

Referring Physician: _____

Primary Care Physician: _____Phone: _____

Problems to be treated: _____

_____

_____

Approximately when did your injury start? _____

_____

Have you had treatment for this problem before? YES NO
If YES, state where:_____ When _____
Treatment given: _____

Have you had surgery associated with this problem? YES NO

What is your current height: _____ current weight: _____

Please list *all* medications on the separate *Medication list* form:

Do you now have / or have you ever had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| High Blood Pressure | YES | NO | Sensitive to Heat/Ice | YES | NO |
| Heart Disease | YES | NO | Allergies | YES | NO |
| Heart Attack | YES | NO | Hernia | YES | NO |
| Pacemaker | YES | NO | Seizures | YES | NO |
| Diabetes | YES | NO | Metal Implants | YES | NO |
| Headaches | YES | NO | Dizzy Spells | YES | NO |
| Kidney Problems | YES | NO | Balance Problems | YES | NO |
| Nervous Disorder | YES | NO | Vision Problems | YES | NO |
| Hearing Problems | YES | NO | Other Illnesses | YES | NO |
| Cancer | YES | NO | Describe_____ | | |
| History of Smoking | YES | NO | Are you pregnant? | YES | NO |

If YES on any of the above, please explain and give approximate dates:_____

_____

Have you had Physical Therapy before for any injury? YES NO If YES, when and for how long?_____

Please provide your intended goals for Physical Therapy involving your current injury._____

_____

_____

The above information is correct to the best of my knowledge.

Signature: _____ Date: _____

# Pain Scale

**Required for all Patients**

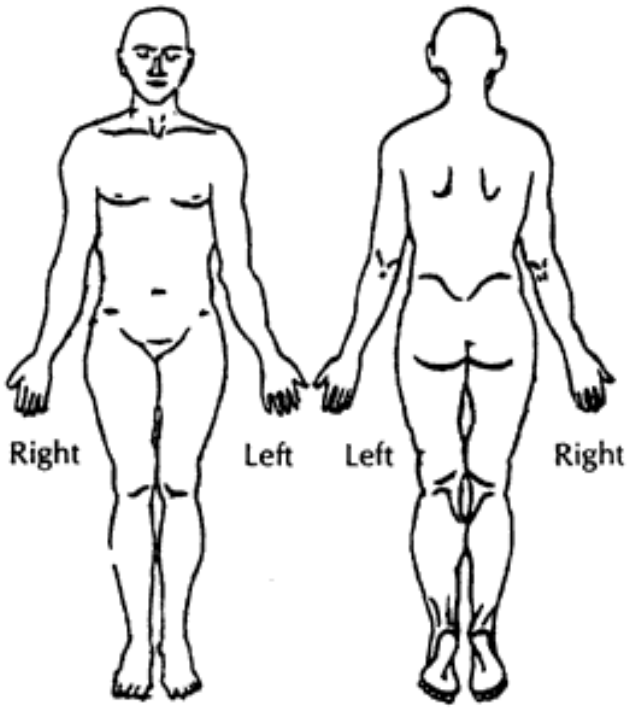
NUMERIC PAIN SCALE

PLEASE RATE YOUR PAIN ON THE FOLLOWING NUMBERIC SCALE, BY CIRCLING THE NUMBER WHICH BEST DESCRIBES YOUR PAIN.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Normal No Pain | Very Weak | Weak | Moderate | | Somewhat Strong | | Strong | Very Strong | Very Very | Emergency |

THE PAIN DRAWING

Indicate your symptoms on the body diagrams using symbols in the key below.




//// Stabbing xxxx Aching 00000 Pins and needles ####Numbness

X_____
Patient Signature

HUNTINGTON BEACH PHYSICAL THERAPY SPECIALISTS

www.HBPTS.com
19582 Beach Blvd. Suite 130
Huntington Beach, CA 92648
714.841.6162

# Consent Form

Patient Name: _____ If minor, parent/guardian name_____

A photocopy of this document and signatures shall be considered as effective and valid as the original.

1. **CONSENT FOR TREATMENT:** I, the undersigned, hereby authorize Huntington Beach Physical Therapy Specialists and/or Tustin Physical Therapy Specialists (the "Clinic") to render services to me/patient, which are deemed necessary by the treating provider.

   **X**_____

   Signature of Patient/Guardian Date

2. **RESPONSIBILITY FOR PAYMENT:** I, the undersigned, take full responsibility for payments for all services rendered by Provider. If I have insurance benefits available, I understand that my insurance is a contract between me and my insurance company and NOT between the provider and my insurance company, and that I will be solely responsible for all billing and collection from the insurance company for all services rendered. The Provider cannot guarantee that the insurance company will pay, even if the policy provides for coverage, or approval was previously granted. Payment is due when services are rendered unless previous arrangements have been provided.

   ***X***_____

   Signature of Patient/Guardian Date

3. **CONFIDENTIALITY & PRIVACY OF PATIENT:** I am aware that my medical information is confidential and may not be shared (except as permitted by law) with anybody without my consent. I am also aware that the staff at the Clinic may view my medical records for continuity of treatment.

   ***X***_____

   Signature of Patient/Guardian Date

4. **AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** I have read and fully understand the Clinic's Notice of Information Practices, the undersigned, consent to the use and disclosure of my personal health information for purposes as noted in the Clinic's Notice of Information and hereby authorizes the Provider and Staff to release information concerning my health acquired in the course of examination, history and treatment to a Physician, Healthcare provider and/or Insurance Carrier, as appropriate.

   ***X***_____

   Signature of Patient/Guardian Date

5. **CANCELLATION POLICY**: PLEASE GIVE 24 HOURS NOTICE IF YOU ARE UNABLE TO MAKE YOUR SCHEDULED APPOINTMENT. A $50 FEE WILL BE INCURRED FOR ANY CANCELLATIONS GIVEN WITHOUT 24 HOURS NOTICE

   AFTER TWO FAILED APPOINTMENTS WITHOUT NOTIFICATION, YOUR REMAINING APPOINTMENTS WILL BE TAKEN OFF THE SCHEDULE UNTIL YOU NOTIFY US BY TELEPHONE OR IN PERSON.
   **I HAVE READ AND AGREE TO THE ABOVE APPOINTMENT & CANCELLATION POLICY.**

   **SCHEDULING**: In order to secure times that you desire, we recommend you schedule follow up visits in advance. It remains your choice to schedule future appointments and your responsibility to continue to schedule for the duration of your treatment.

   ***X***_____

   Signature of Patient/Guardian Date

6. **EMAIL:** Please keep in mind that communication via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

Please initial here _____Date:_____

HUNTINGTON BEACH
PHYSICAL THERAPY
SPECIALISTS

# Medication List

*Required for all patients*

PATIENT NAME_____ DATE_____

| Name of Medication/Vitamins/Supplements | Dosage/Frequency | Purpose of Medication |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
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*(Attn: Medicare Patients: Due to new changes implemented by Medicare and CMS, we are asking you to please list all the medications, supplements, vitamins, and herbs that you currently take, along with their respective dosages, frequency and purpose. These new regulations have been implemented in an effort to improve quality care and reporting for all Medicare patients. Many medications and vitamins can affect your musculoskeletal system and informing us of them will help ensure the best possible treatment for you and your overall health.)*

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# Fall Efficacy Scale

(Required for all **Medicare** patients only)

Patient Name _____ Date _____

*Pursuant to Medicare guidelines we are required to assess any risk for falls and provide an appropriate plan of care or advice for assistive device.*

1. Have you had two or more falls in the past year? Yes No
   If YES, when? _____

2. Were there any injuries caused by these falls? Yes No
   If YES, in what area? _____

On a scale from 1 to 10, with ***1 being very confident and 10 being not confident at all***, how confident are you that you do the following activities without falling?

**Take a bath or shower**

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

**Reach into cabinets or closets**

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

**Walk around the house**

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

**Prepare meals not requiring carrying heavy or hot objects**

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

**Get in and out of bed**

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

**Answer the door or telephone**

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

**Get in and out of a chair**

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

**Getting dressed and undressed**

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

**Personal grooming (i.e. washing your face)**

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

**Getting on and off of the toilet**

(Very Confident) 1 2 3 4 5 6 7 8 9 10 (Not at all Confident)

**PATIENT NAME:** _____ **ID#:** _____ **DATE:** _____

**Description**: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

**1.** Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

**2.** How satisfied are you with the level of care and service provided? **Very Satisfied / Satisfied / Unsatisfied / Very Unsatisfied**

**3.** Please rate your progress with functional activities from start of therapy to this point in time. **Excellent / Good / Fair / Poor**

**4.** At this point in your treatment, have your therapy goals been met? **Completely Met / Mostly Met / Partially Met / Not Met**

## OSWESTRY DISABILITY SCALE – FOLLOW-UP AND FINAL VISIT

**1. Pain Intensity**
(0) I can tolerate the pain I have without having to use pain medication.
(1) The pain is bad, but I can manage without having to take pain medication.
(2) Pain medication provides me with complete relief from pain.
(3) Pain medication provides me with moderate relief from pain.
(4) Pain medication provides me with little relief from pain.
(5) Pain medication has no effect on my pain.

**2. Personal Care (washing, dressing, etc.)**
(0) I can take care of myself normally without causing increased pain.
(1) I can take care of myself normally, but it increases my pain.
(2) It is painful to take care of myself, and I am slow and careful.
(3) I need help, but I am able to manage most of my personal care.
(4) I need help every day in most aspects of my care.
(5) I do not get dressed, wash with difficulty, and stay in bed.

**3. Lifting**
(0) I can lift heavy weights without increased pain.
(1) I can lift heavy weights, but it causes increased pain.
(2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
(3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

**4. Walking**
(0) Pain does not prevent me from walking any distance.
(1) Pain prevents me from walking more than 1 mile.
(2) Pain prevents me from walking more than ½ mile.
(3) Pain prevents me from walking more than ¼ mile.
(4) I can only walk with crutches or a cane.
(5) I am in bed most of the time and have to crawl to the toilet.

**5. Sitting**
(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like.
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting more than ½ hour.
(4) Pain prevents me from sitting more than 10 minutes.
(5) Pain prevents me from sitting at all.

**6. Standing**
(0) I can stand as long as I want without increased pain.
(1) I can stand as long as I want but, it increases my pain.
(2) Pain prevents me from standing more than 1 hour.
(3) Pain prevents me from standing more than 1/2 hour.
(4) Pain prevents me from standing more than 10 minutes.
(5) Pain prevents me from standing at all.

**7. Sleeping**
(0) Pain does not prevent me from sleeping well.
(1) I can sleep well only by using pain medication.
(2) Even when I take pain medication, I sleep less than 6 hours.
(3) Even when I take pain medication, I sleep less than 4 hours.
(4) Even when I take pain medication, I sleep less than 2 hour
(5) Pain prevents me from sleeping at all.

**8. Social Life**
(0) My social life is normal and does not increase my pain.
(1) My social life is normal, but it increases my level of pain.
(2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
(3) Pain prevents me from going out very often.
(4) Pain has restricted my social life to my home.
(5) I have hardly any social life because of my pain.

**9. Traveling**
(0) I can travel anywhere without increased pain.
(1) I can travel anywhere, but it increases my pain.
(2) My pain restricts my travel over 2 hours.
(3) My pain restricts my travel over 1 hour.
(4) My pain restricts my travel to short necessary journeys journeys under 1/2 hour.
(5) My pain prevents all travel except for visits to the physician/therapist or hospital.

**10. Employment / Homemaking**
(0) My normal homemaking/job activities do not cause pain.
(1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
(2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
(3) Pain prevents me from doing anything but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job or homemaking chores.