

# Patient Information Form

-Please Print-

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ SEX: M F AGE: \_\_\_\_\_

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

DRIVERS LICENSE # \_\_\_\_\_ HOW DID YOU HEAR OF US? \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_ PHYSICIAN'S PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

EMERGENCY CONTACT'S PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM PATIENT)

FULL NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_ EMPLOYER PHONE # \_\_\_\_\_

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? \_\_\_\_\_

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) 41-6162  
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# 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: \_\_\_\_\_



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# Pain Scale

Required for all Patients

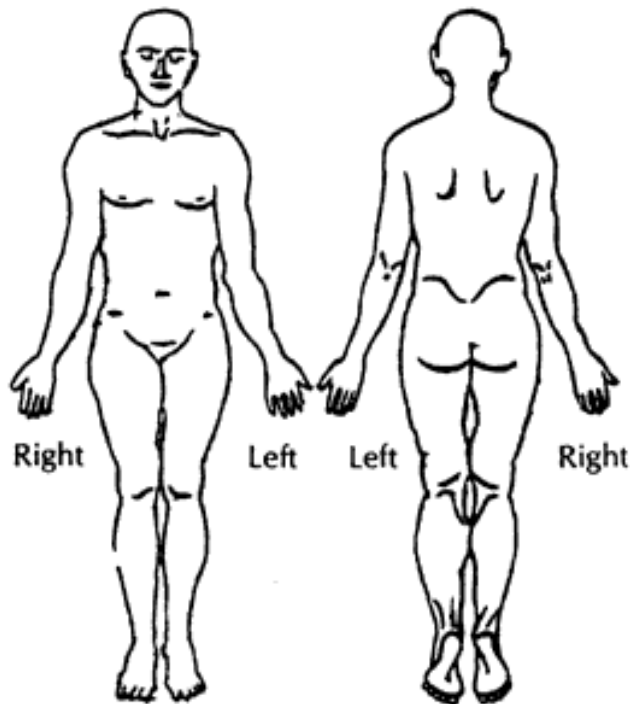
## NUMERIC PAIN SCALE

PLEASE RATE YOUR PAIN ON THE FOLLOWING NUMERIC 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



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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)



# 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 \$35 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.**

X

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

6. SCHEDULING: In order to secure times that you desire, we recommend that you schedule at least two weeks of appointments, up to the length of your prescription, but it remains your choice to schedule future appointments and your responsibility to continue to schedule for the duration of your treatment.

Please initial here \_\_\_\_\_

## THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb  
 Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

**Today, do you or would you have any difficulty at all with:**

Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1 Any of your usual work, housework, or school activities.	0	1	2	3	4
2 Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3 Getting into or out of the bath.	0	1	2	3	4
4 Walking between rooms.	0	1	2	3	4
5 Putting on your shoes or socks.	0	1	2	3	4
6 Squatting.	0	1	2	3	4
7 Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8 Performing light activities around your home.	0	1	2	3	4
9 Performing heavy activities around your home.	0	1	2	3	4
10 Getting into or out of a car.	0	1	2	3	4
11 Walking 2 blocks.	0	1	2	3	4
12 Walking a mile.	0	1	2	3	4
13 Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14 Standing for 1 hour.	0	1	2	3	4
15 Sitting for 1 hour.	0	1	2	3	4
16 Running on even ground.	0	1	2	3	4
17 Running on uneven ground.	0	1	2	3	4
18 Making sharp turns while running fast.	0	1	2	3	4
19 Hopping.	0	1	2	3	4
20 Rolling over in bed.	0	1	2	3	4
<b>Column Totals:</b>					

**Minimum Level of Detectable Change (90% Confidence): 9 points**

**SCORE: \_\_\_\_\_ / 80**

**Please submit the sum of responses to ACN.**

*Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network. The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.*