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 # _____

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: _____

Medication List

Required for all patients

PATIENT NAME_____ DATE_____

Name of Medication/Vitamins/Supplements	Dosage/Frequency	Purpose of Medication

(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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Huntington Beach, CA 92648
714.841.6162

Pain Scale

Required for all Patients

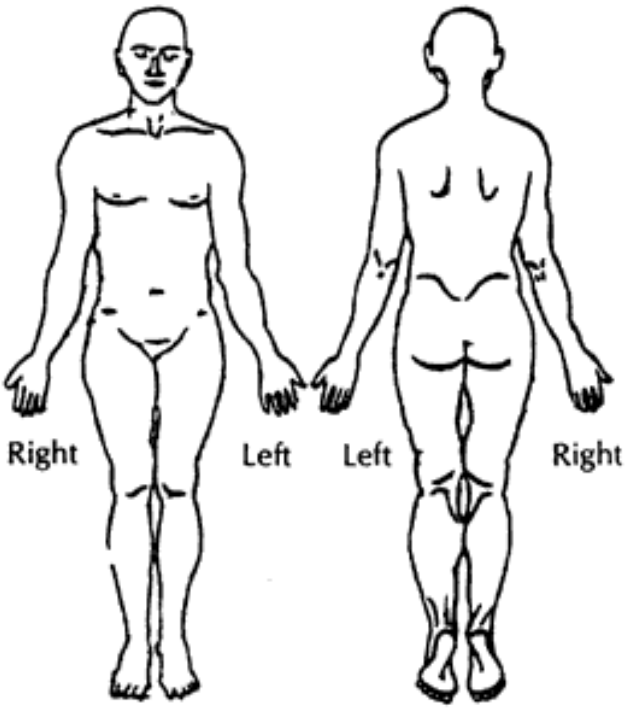
NUMERIC PAIN SCALE

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

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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)

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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.

   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:_____

APPENDIX M

Constipation Scoring System

(Agachan et al., 1996)

Name: _____ Date: _____

Frequency of bowel movements

0	1-2 times per 1-2 days
1	2 times per week
2	Once per week
3	Less than once per week
4	Less than once per month

Difficulty: painful evacuation effort

0	Never
1	Rarely
2	Sometimes
3	Usually
4	Always

Completeness: feeling incomplete evacuation

0	Never
1	Rarely
2	Sometimes
3	Usually
4	Always

Pain: abdominal pain

0	Never
1	Rarely
2	Sometimes
3	Usually
4	Always

Time: minutes in lavatory per attempt

0	Less than 5
1	5-10
2	10-20
3	20-30
4	More than 30

Assistance: type of assistance

0	Without assistance
1	Stimulative laxatives
2	Digital assistance or enema

Failure: unsuccessful attempts for evacuation per 24 hours

0	Never
1	1-3
2	3-6
3	6-9
4	More than 9

History: duration of constipation (yr)

1	0
2	1-5
3	5-10
4	10-20
5	More than 20

TOTAL SCORE: _____

(Minimum Score, 0; Maximum Score, 30)