RET Physical Therapy Group

PATIENT INFORMATION

First Name:_____ M.I. _____ Last Name:_____

Address: _____ City, State: _____ Zip Code: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: M / F

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other:_____

Home #:(_____) _____ Cell #:(_____) _____ Work #:(_____) _____

Please note whether we have permission to leave a detailed message on your answering machine if we are unable to reach you in person. Home: ☐ Yes ☐ No Cell: ☐ Yes ☐ No Work: ☐ Yes ☐ No

Email Address: _____ *RET PT Group will not share, sell or trade your information*

Automated Appointment Reminder preference: ☐ Email ☐ SMS/Text on Cell ☐ Voice Call on Cell/Home/Work

Diagnosis or Chief complaint(s): _____

Date of Injury/Onset: _____ Did you have surgery? ☐ Yes ☐ No If yes, when? _____

Referring Doctor: _____ Clinic/Hospital: _____

Patient's Employer: _____ Patient's Spouse or Parent: _____

Is this work related? Yes/No **If yes**, Date of Injury: _____
Employer at Time of Injury:_____

Is this Motor Vehicle Accident related? Yes/No **If yes**, State _____ and Date of accident:_____

If patient is under the age of 18, name of parent/guardian completing and signing documentation:

Name: _____ DOB: _____ Relationship: _____

- I hereby authorize and consent to treatments/services for myself, or on the behalf of the above-named patient, performed by the staff at RET Physical Therapy Group and/or as directed by my referring physician.
- I assign medical benefits payable for these services directly to RET Physical Therapy Group. I authorize the release of any medical or other information necessary to process claims for these services.
- I understand that I am responsible for payment of any applicable co-payments, co-insurance, deductibles or non-covered services at the time of service. In Medicare assigned cases, RET Physical Therapy Group participates in the Medicare program and accepts Medicare's allowed amount for covered services, less any co-pay, co-insurance, deductible or non-covered services.
- In signing this form, I acknowledge that I am responsible for the bill not paid by the insurance carrier.
- I understand that my health information will be used for treatment, payment and healthcare operations in accordance with the Notice of Privacy Practices.
- By providing your contact information, you agree to receive information, such as appointment reminders, patient surveys and other information relating to your therapy services via the communication channels you provided above.

Signed: _____ **Date:** _____
(Patient/Legal Guardian Signature if under 18 years old)

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PATIENT INFORMATION (continued)

How did you hear about us? (Please check one):

☐ Doctor ☐ Friend/Relative ☐ Return Patient ☐ Phone Book ☐ RET Website ☐ Internet Search
☐ Clinic Sign ☐ Insurance List ☐ Charity Event ☐ Seminar ☐ Newspaper ☐ Other RET Clinic
☐ Community Event ☐ Other: _____

In case of emergency, please contact: (List a friend or relative that can be reached during office hours)

Name: _____ Phone #: (_____) _____ Relationship: _____

CANCELLATION AND BROKEN APPOINTMENT POLICY

We would like you to be aware of our cancellation and broken appointment policy. **Any appointments cancelled or broken within 24 hours of their scheduled time will be assessed a $50 fee.**

Successful therapy is dependent on a strong working relationship between the patient and the physical therapist. Maximum progress and success are made when the patient is an active participant in their home exercise program and attends all appointments prescribed by their therapist. **It is very important to attend each appointment when it is scheduled.**

If a cancellation is unavoidable we do ask that you give us as much notice as possible so we may offer that appointment to another patient. If you arrive later than 15 minutes after the scheduled appointment time, we may ask to reschedule that appointment or may offer you a shorter treatment time based on what our schedule allows.

By signing below, you acknowledge that you have read our policy and understand your commitment to a successful physical therapy outcome is essential. The cancellation fee is not covered by insurance and will be collected at the time of your next visit or billed directly to you as an out of pocket expense.

Signed: _____ **Date:** _____
(Patient/Legal Guardian Signature if under 18 years old)

RECEIPT OF PRIVACY PRACTICES

By signing below, you acknowledge receipt of the Notice of Privacy Practices of RET PT Group. You are also authorizing RET PT Group to release your records to your insurance company and physician. Please understand your records are held in strict confidence and we will not release them to any unauthorized person. Our Notice of Privacy Practices provides further information about how we may use and disclose your protected health information. We encourage you to read it in full.

Signed: _____ **Date:** _____
(Patient/Legal Guardian Signature if under 18 years old)

Please include the names of persons with whom we can discuss your condition and/or billing information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize RET PT Group to discuss my medical and/or billing information with the above-named person(s).

Signed: _____ **Date:** _____
(Patient/Legal Guardian Signature if under 18 years old)

RET Physical Therapy Group

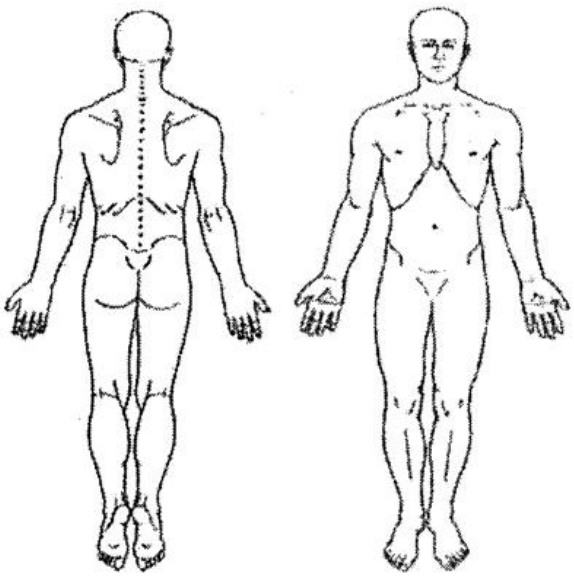
HISTORY OF PRESENT CONDITION

What are you seeing us for? _____

_____

_____

Please indicate where you have pain/symptoms:



When did this issue begin? _____

Describe the history of this problem (i.e. how did it occur?): _____

_____

_____

Was the onset of your symptoms gradual or sudden?

☐ gradual ☐ sudden

Overall, are your symptoms:

☐ improving ☐ getting worse ☐ no change

Have you had similar symptoms in the past?

☐ Yes ☐ No

How would you describe your symptoms? (select all that apply)

☐ sharp ☐ throbbing
☐ dull ☐ shooting
☐ numbness ☐ aching
☐ tingling ☐ burning
☐ other:_____

Please indicate the average intensity of your symptoms (0-lowest, 10-highest):

0 5 10

As you go through your day, do your symptoms:

☐ increase ☐ decrease ☐ stay the same

Does pain ever wake you up at night?

☐ Yes ☐ No

What aggravates your symptoms?

☐ sitting ☐ standing
☐ lying down ☐ bending forward
☐ walking/running ☐ sleeping
☐ up/down stairs ☐ coughing/sneezing
☐ reaching overhead ☐ turning/twisting body
☐ lifting objects ☐ sustained movements
☐ playing a sport ☐ stress
☐ repetitive activities ☐ other _____

Does anything relieve your symptoms? Please explain:

_____

_____

Have you had any previous treatment or tests for this condition? (select all that apply)

☐ physical therapy ☐ x-ray
☐ massage therapy ☐ MRI
☐ chiropractic care ☐ CT scan
☐ traction ☐ EMG
☐ bracing/taping ☐ bone scan
☐ hospitalization ☐ acupuncture
☐ bed rest ☐ casting
☐ exercise ☐ medication/injection
☐ home health care ☐ other _____

Please list any current medications, including over the counter and supplements: _____

_____

_____

_____

_____

Patient Name (Printed):_____ **Date:**_____

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HISTORY OF PRESENT CONDITION continued

Since your symptoms began, have you had any of the following?

- ☐ bowel or bladder issues
- ☐ weakness
- ☐ dizziness or fainting
- ☐ fever/chills/sweats
- ☐ significant weight change
- ☐ hearing or vision problems
- ☐ numbness or tingling
- ☐ difficulty swallowing
- ☐ pain at night
- ☐ numbness in the anal or genital area
- ☐ vague feeling of bodily discomfort
- ☐ NONE

Are you currently able to perform all of your regular work/home duties? ☐ Yes ☐ No

If no, please list activities that you are not able to do: _____

_____

In general, would you say your overall health is:

Poor — Excellent

Your exercise/activity level is:

Inactive — Very Active

If active, please describe: _____

_____

Do you smoke? ☐ Yes ☐ No

_____ packs/day _____ packs/week

Do you drink alcohol? ☐ Yes ☐ No

_____ drinks/day _____ drinks/week

Occupation: _____

Does your job include any of the following?

☐ sitting ☐ standing ☐ lifting

What is your current living situation? (select all that apply)

- ☐ live alone
- ☐ live with family/friends
- ☐ home/apartment
- ☐ single level/no stairs
- ☐ multiple levels/stairs
- ☐ have caregiver
- ☐ retirement community
- ☐ assisted living
- ☐ other : _____

Do you currently have or have you had a history of any of the following? (select all that apply)

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Cancer/Tumor
- ☐ IBD (Crohn's, UC)
- ☐ Anemia
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Nausea/Vomiting
- ☐ Cardiac arrhythmias
- ☐ Pacemaker
- ☐ Blood clots
- ☐ Peripheral Vascular Disease
- ☐ Bruising easily
- ☐ Neurological conditions
- ☐ Sleep disorder
- ☐ Seizures/Epilepsy
- ☐ Thyroid problems
- ☐ Pulmonary conditions
- ☐ Multiple Sclerosis
- ☐ Kidney problems
- ☐ Parkinson's disease
- ☐ Fractures
- ☐ Joint replacement
- ☐ Arthritis/Swollen joints
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Dizziness/Vertigo
- ☐ Loss of balance/Falls
- ☐ Shortness of breath
- ☐ Infectious disease
- ☐ Use of steroids/inhalants
- ☐ Currently pregnant
- ☐ Depression
- ☐ Chemical dependency
- ☐ Sensitivity to heat/ice
- ☐ Allergy to adhesive/ tape/lotions
- ☐ Angina
- ☐ Coronary Artery Disease

Please list any PREVIOUS surgeries:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Patient Signature: _____ **Date:** _____ WV10.2016