PRO~PT

Personal Information

Name: _____ | Employer: _____

Date of Birth: _____ | Address: _____

Social Security Number: _____ | City: _____ St: _____ Zip: _____

Address: _____ | Work Phone: _____

City: _____ St: _____ Zip: _____ | Occupation: _____

Primary Phone: _____ | Email: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referring Doctor: _____ Primary Doctor: _____

Please check below ***how you initially heard about PRO-PT***?

☐Physician ☐Previous Patient ☐Family/Friend ☐Coach ☐Facebook ☐Website ☐Other: _____

Insurance

Primary Plan Name: _____ | Secondary Plan Name: _____

ID #: _____ | ID #: _____

Group #: _____ | Group #: _____

Subscriber Name: _____ | Subscriber Name: _____

Relation to Patient: _____ | Relation to Patient: _____

Date of Birth: _____ | Date of Birth: _____

Important Questions

Are you currently receiving ***Home Health Care*** from a Nurse, PT, OT, or Speech Pathologist? ☐Yes ☐No

Have you had any of the following services ***this calendar year***? If so, indicate location and # of Visits:

Physical Therapy	☐Yes ☐No	Location: _____	# of Visits: _____
Occupational Therapy	☐Yes ☐No	Location: _____	# of Visits: _____
Cardiac Therapy	☐Yes ☐No	Location: _____	# of Visits: _____
Chiropractic	☐Yes ☐No	Location: _____	# of Visits: _____
Speech Therapy	☐Yes ☐No	Location: _____	# of Visits: _____

Is this a ***Worker's Compensation Claim***? ☐Yes ☐No If Yes, date of injury: _____

Was this a ***motor vehicle accident***? ☐Yes ☐No If Yes, date of accident: _____

Pertinent Medical Information

In your own words, please ***explain*** your problem:

_____

_____

_____

_____

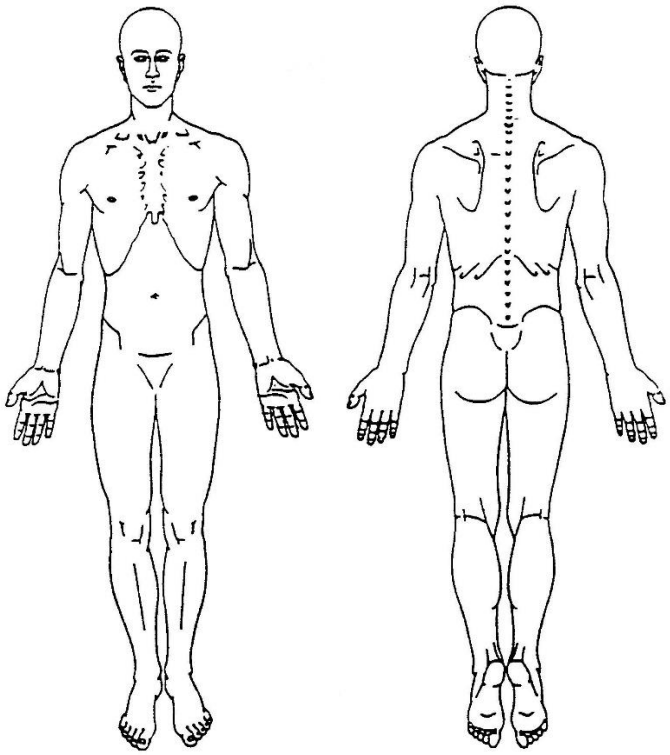
Please indicate ***when*** your problem began:

Date Your Problem Began: _____ Date of Surgery, if applicable: _____

Please indicate ***how often*** your symptoms are present: ☐Constantly ☐Intermittently ☐Never

Since your symptoms have begun is your problem: ☐ Improving ☐ Worsening ☐ Not Changing

Utilizing the body chart image below, please indicate ***where*** you feel your symptoms:



Please check *all* answers that ***describe*** your pain:

☐ Sharp/Stabbing ☐ Soreness ☐ Shooting ☐ Catching
☐ Throbbing ☐ Weakness ☐ Burning ☐ Popping
☐ Aches ☐ Numbness ☐ Tingling ☐ Giving Out
☐ Dull ☐ Other: _____

Please check *all* activities that ***aggravate*** your pain:

☐ Reaching Overhead ☐ Looking Up
☐ Carrying Objects ☐ Looking Down
☐ Lifting ☐ Turning Head
☐ Reaching Behind Back ☐ Sitting
☐ Putting Shirt On or Off ☐ Driving
☐ Participation in Sport ☐ Other: _____
☐ Lying Down

Please check *all* activities that ***ease*** your pain:

☐ When Still ☐ In the Morning ☐ Bending
☐ When Moving ☐ In the Evening ☐ Sitting
☐ Lying ☐ As the Day Progresses
☐ Other: _____

Utilizing the scale below, mark a level for the ***least*** amount of pain you have in a day, and one for the ***most***.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain Unbearable Pain

Please identify up to ***3 important activities*** that you are unable to do, or have difficulty with as a result of your problem (examples: sport, recreational activity, playing with children or grandchildren, specific work tasks):

1.

2.

3.

Please indicate what type of ***imaging*** you have received for this injury:

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan Results: _____

Please ***list all medications*** you are currently taking, or ***provide a list*** we may copy:

☐ I am not currently taking any medication

Medications		

Please list any known ***allergies***: _____

_____

Please ***indicate if you have, or have had***, any of the following:

☐ Heart Disease	☐ Diabetes	☐ Headaches	☐ Latex Allergy
☐ Stent Placement-Date:	☐ Stroke-Date:	☐ Asthma	☐ Psychiatric/Psychological Care
☐ Heart Attack-Date:	☐ Arthritis	☐ Tumors	☐ Depression
☐ Congestive Heart Failure	☐ Pregnant	☐ Bladder Problems	☐ Hepatitis (A,B,C)
☐ Pacemaker	☐ Falls	☐ HIV/AIDS	☐ Cancer - Type: _____
☐ High Blood Pressure	☐ Dizziness/Vertigo	☐ Seizures	☐ Other:
☐ COPD	☐ Fainting	☐ Nausea/Vomiting	

Please list any ***major operations*** you have had:

_____

_____

Financial Policy

Please ***read and initial*** next to each statement indicating that you have read and understand PRO-PT's financial policy.

Initial

_____ All co-pays and patient responsibility portions are due at time of services (when applicable) as indicated by the financial form that is provided for me by PRO-PT at the time of the initial evaluation.

_____ Payment is due in full at time of service unless other arrangements have been made. You are responsible for all durable goods at time of acceptance of goods. We accept cash, checks, and some types of credit cards. PRO-PT will set up a payment plan for balances on an individual basis, as deemed necessary.

_____ If payment is not received from the insurance carrier or other responsible third party in 90 days, we have the right to bill you directly. Please notify us immediately of any changes in your insurance or coverage.

_____ Twenty-four-hour notice is required for copies of medical records and there may be a nominal fee.

_____ **PRO-PT reserves the right to charge $25 for any appointments where the patient no-shows or does not cancel within a 24-hour period of their appointment.**

_____ I know that verification is not a guarantee of payment and that I am responsible for any unpaid balances left after my insurance.

I authorize PRO-PT to provide me with physical therapy services and to furnish further information to my insurance company, worker's compensation carrier, caseworker, attorney, and my physician concerning my injury and treatment. I understand that I am financially responsible for payment of all services rendered.

Signature: _____ Date: _____

Work Comp/ Veterans

Initial

_____ **WC** - I understand that if I no show or fail to cancel within a 24 hour period of my appointment PRO-PT is contractually obligated to notify my adjuster.

_____ **VA** – I understand that if I no show or have excessive cancellations, my treatment can be terminated.

I authorize PRO-PT to provide me with physical therapy services and to furnish further information to my insurance company, worker's compensation carrier and my physician concerning my injury and treatment.

Signature: _____ Date: _____