IMPORTANT QUESTIONS

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

☐ Yes ☐ No Have you had any **physical** therapy this calendar year?

If yes: _____# of **physical** therapy visits

Location where therapy performed:_____

☐ Yes ☐ No Have you had any **occupational** therapy this calendar year?

If yes: _____# of **occupational** therapy visits

Location where therapy performed:_____

☐ Yes ☐ No Have you had any **speech** therapy this calendar year?

If yes: _____# of **speech** therapy visits

Location where therapy performed:_____

☐ Yes ☐ No Have you had any **cardiac** therapy this calendar year?

If yes: _____# of **cardiac** therapy visits

Location where therapy performed:_____

☐ Yes ☐ No Have you had any **chiropractic care** this calendar year?

If yes: _____# of **chiropractor** visits

Location where you had chiropractor care:_____

☐ Yes ☐ No Is this a Worker's Compensation Claim?

☐ Yes ☐ No If this is a Worker's Compensation Claim, are you currently working?

☐ Yes ☐ No Was this a motor vehicle accident?

If yes – Date of accident:_____

☐ Yes ☐ No Was this a sports injury?

If yes – Date of injury:_____

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

☐ Physician ☐ Previous Patient ☐ Family/Friend ☐ Coach ☐ Facebook ☐ Website

Patient e-mail:_____

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Patient Information

Name_____

Address_____

City_____St_____Zip_____

Date of Birth_____

Social Sec #_____

Home Phone_____Cell_____

Employer_____

Address_____

City_____St_____Zip_____

Work Phone_____

Occupation_____

Spouse/Parent Information

Name_____

Address_____

City_____St_____Zip_____

Date of Birth_____

Social Sec #_____

Home Phone_____Cell_____

Employer_____

Address_____

City_____St_____Zip_____

Work Phone_____

Occupation_____

Patient Status (Check all that apply)

☐ Full Time ☐ Part Time ☐ Student ☐ Single ☐ Married ☐ Other

Emergency Contact_____Phone_____Relationship_____

Referring Doctor_____ Primary Doctor_____

Insurance

☐ Please check if this is Worker's Comp

Primary Plan Name_____

ID #_____

Group #_____

Subscriber Name_____

Date of Birth_____

Secondary Plan Name_____

ID#_____

Group # _____

Subscriber Name_____

Date of Birth_____

PERTINENT MEDICAL INFORMATION

Please describe your problem and how it began. Date Problem Began: _____/_____/_____ Date of Surgery: _____/_____/_____

_____

_____

_____

_____

How often are your symptoms present?	☐ Constantly	☐ Intermittently	☐ Never
Describe your current problem:	☐ Difficulty walking	☐ Imbalance	☐ History of falls
	☐ Weakness	☐ Fatigue	☐ Dizziness
	☐ Ringing in ears	☐ Other_____	
If you are dizzy, please describe:	☐ Spinning	☐ Tilting	☐ Imbalance
	☐ Light-headedness	☐ Other_____	
My dizzy episodes occur…	☐ When I lay down or roll over in bed	☐ In relation to any head motion	☐ when standing or walking
	☐ Nothing I do seems to bring them on or turn them off		
Did you have a cold, flu, or virus type symptoms shortly before the onset of your dizziness?	☐ Yes	☐ No	
Is your dizziness connected with your menstrual period?	☐ Yes	☐ No	☐ N/A
How many falls in the past year?	☐ 0	☐ 1	☐ 2
	☐ 3	☐ 4	☐ 5+
Last fall occurred about	☐ 1 week ago	☐ 1 month ago	☐ 1-3 months ago
	☐ 4-6 months ago	☐ 7-12 months ago	☐
What is the physical layout of your home?	☐ Steps into home	☐ Steps in home	☐ Two story home
	☐ Mobile home	☐ Throw rugs	☐ Grab bars
	☐ Ramp present to enter home	☐ Bath chair or bench	☐ Nightlights
Do you have a caretaker?	☐ None	☐ Part-time	☐ Full-time
What type of assistive devices do you use?	☐ None	☐ Single point cane	☐ Quad cane
	☐ Four wheeled walker	☐ Front wheeled walker	☐ Manual wheelchair
	☐ Power chair	☐ Lift chair	
Occupation	☐ Retired	☐ Other_____	

Since it began, is your problem:	☐ Improving	☐ Worsening	☐ Not Changing
Can you perform your daily home activities?	☐ Yes	☐ Some	☐ None
Describe your job requirements:	☐ Mainly sitting	☐ Light labor	☐ Heavy labor
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only some	☐ Not at all

Please rate your pain on the scale below. Please mark a level for the least amount of pain you have in a day and for the most.

☐ Check here if not applicable

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
No Pain										Unbearable Pain

Have you received treatment for these symptoms before? ☐ Yes ☐ No

If YES what type:_____

_____

_____

_____

_____

What are you goals for attending physical therapy (i.e. return to golf, able to garden, etc.):_____

_____

_____

_____

_____

THIS AREA INTENTIONALLY LEFT BLANK

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INDICATE IF YOU HAVE ANY OF THE FOLLOWING BY CHECKING THE CORRECT RESPONSE:

Past	Present	Condition	Past	Present	Condition
☐	☐	Neck pain	☐	☐	Depression
☐	☐	Shoulder Pain (R__L__)	☐	☐	Fainting
☐	☐	Pain in Upper Arm or Elbow (R__L__)	☐	☐	Chest Pain
☐	☐	Hand Pain (R__L__)	☐	☐	Heart Attack (date_____)
☐	☐	Wrist Pain (R__L__)	☐	☐	Stroke (date_____)
☐	☐	Mid Back Pain	☐	☐	Asthma
☐	☐	Low Back Pain	☐	☐	Cancer
☐	☐	Pain in Upper Leg or Hip (R__L__)	☐	☐	Tumors
☐	☐	Pain in Lower Leg or Knee (R__L__)	☐	☐	Bladder Problems
☐	☐	Jaw Pain	☐	☐	HIV/AIDS
☐	☐	Sprains/Strains	☐	☐	Seizures
☐	☐	Dizziness/Vertigo	☐	☐	Nausea/Vomiting
☐	☐	Falls	☐	☐	Latex Allergy
☐	☐	Headaches	☐	☐	Psychiatric/Psychological Care
☐	☐	Arthritis	☐	☐	Hepatitis (A,B,C)
☐	☐	Pacemaker	☐	☐	Are you pregnant?
☐	☐	High Blood Pressure	☐	☐	Diabetes

If you answered yes to any of the previous, please explain:

_____

_____

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Are you currently taking medication? □ Yes □ No

Please list all medications you are currently taking:

Medication	Dosage	Frequency	If not by mouth please indicate

Please list any known allergies:_____

_____

_____

_____

_____

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:____/____/____