OUTPATIENT PHYSICAL THERAPY

HOW DID YOU HEAR ABOUT OUR CLINIC: ____

FIRST NAME: ______________________________MI: _____ LAST NAME: ______________________________________

ADDRESS:____
Street Address & P.O. Box if Applicable City State Zip

HOME PHONE: ___________________________WORK PHONE: __________________________MALE_____ FEMALE_____

CELLPHONE: ____________________________________ DOB: __________________ SS# ____________________________

EMERGENCY CONTACT: ___________________________PHONE:____________________RELATIONSHIP:____________

PRIMARY CARE PROVIDER: _____________________________________ PHONE: __________________________________

REFERRING DOCTOR: ____ PHONE: ___________________________________

DATE OF (Circle One) INJURY / CONDITION / ACCIDENT : _______________ DATE OF SURGERY: _______________

EMPLOYMENT STATUS (Circle one): FT PT Retired Not Working Disability Self-Employed Homemaker Student

EMPLOYER/JOB TITLE: _______________________________________ EMAIL: _________________________________

MARITAL STATUS (Circle one): SINGLE MARRIED DIVORCED WIDOW/ WIDOWER DOMESTIC PARTNER

PRIMARY INSURANCE

WHAT IS YOUR PRIMARY HEALTH INSURANCE: ____

SUBSCRIBER'S NAME & RELATIONSHIP____ ___________________
SUBSCRIBERS DOB

ID#____ GROUP#____

SECONDARY INSURANCE

WHAT IS YOUR SECONDARY HEALTH INSURANCE: ____

SUBSCRIBER'S NAME & RELATIONSHIP____ ___________________
SUBSCRIBERS DOB

ID#____ GROUP#____

IS YOUR INJURY JOB RELATED & DO YOU HAVE AN OPEN CLAIM? YES NO CLAIM # _____________________

EMPLOYER:_______________________CLAIMS MANAGER: _______________________ PHONE: ____________________

BILLING ADDRESS FOR SELF-INSURED COMPANIES: ____

IS YOUR INJURY DUE TO A MVA? YES NO THAT OCCURRED IN:_____ ARE YOU COVERED BY PIP*? YES NO
STATE

AUTO POLICY HOLDER: ____ CLAIM #__________________________________

PIP ADJUSTER: ____________________________________ PHONE: ____

PIP BILLING ADDRESS: ____

For those with DSHS insurance

DSHS COVERS 12 THERAPY VISITS PER CALENDAR YEAR. HAVE YOU RECEIVED PT THIS YEAR? YES ___ NO ___

PLEASE SEE REVERSE SIDE

OUTPATIENT PHYSICAL THERAPY
OUR FINANCIAL POLICY

Thank you for choosing **OUTPATIENT PHYSICAL THERAPY** as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the physical therapist.

Payment Policy

We bill all CONTRACTED insurance carriers, however if you fail to bring your insurance information with you to your first appointment, payment will be required at the time of service. All co pays are due at the time of service. Due to rising costs of billing by our facility, we now have the following options for payment of your bill: We accept cash, checks, VISA, MasterCard and Care Credit. We do understand that patients may experience financial problems occasionally. If you need to arrange a payment plan, please contact our Business Office at 425-413-4405.

Regarding Insurance

We accept assignment of insurance benefits after your first visit. Our Financial Policy requires payment in full of any balance billed to you by our facility within 30 days of receiving a statement. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance may be automatically transferred to you. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You are responsible for providing any/all information sent to you by your insurance company as no return of this information will result in payment being delayed or denied, thereby becoming your responsibility

Regarding Insurance Plans where we are a participating provider: In the event that your insurance coverage changes to a plan where we are not participating providers, please refer to the above paragraph. In the instance that our fees go towards meeting your yearly deductible, this deductible amount will be billed to you and payable within 30 days of receipt of statement.

I hereby authorize my insurance company to make payment directly to Outpatient Physical Therapy for any benefits I may receive. I authorize the release of any information necessary to process my insurance claims, or facilitate payment of my account by a third party.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Motor Vehicle Accidents

Your automobile insurance carrier will be billed for services. We do not accept any insurance company’s arbitrary determination of usual and customary fees. It will be your responsibility for payment of any balance due. It is not the policy of this office to delay the collection of charges that are being claimed in any type of litigation. Payment will be expected as our policy specifies.

Minor Patients

The adult accompanying a minor or the parents (or guardians of the minor) are responsible for full payment after insurance has paid their portion. For unaccompanied minors, physical therapy will be given only with the consent and signature of our Information and Financial Policy by the parent or custodial guardian. Co-pay arrangements will stand as referenced above. It may be necessary for the minor patient to call the responsible party for Visa or MasterCard information to process his/her co-pay before receiving treatment.

Missed appointments

Unless canceled, except for a genuine emergency, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of **$25.00** per visit,. Please help us serve you better by keeping scheduled appointments.

Interest

We reserve the right to charge interest in the amount of 1.5% per month for each month payment is not received. If you have a remaining balance after 60 days your account may be placed for outside collection. In the event that fees are incurred with the collection of my account, I will pay such costs and fees, including collection agency fees, attorney fees and all court costs.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read, understand and agree to the Financial Policy.

X ____ **Date** ______________________________________
Signature of Patient or Responsible Party

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We at Outpatient Physical Therapy keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so or unless a legal request authorizes or compels us to do so. We will provide copies of your records to your insurance company as necessary to receive payment for our services. If you would like a copy of these records we would be happy to provide them to you for a small fee of $15.00. You may see your records or get more information about them by contacting Outpatient Physical Therapy.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

___________________________________ _________________________

Patient or legally authorized individual signature Date

___________________________________ ________________________

Printed name if signed on behalf of the patient Relationship

This form will be retained in your medical record.

Outpatient Physical Therapy

Auburn	Covington	Covington Satellite	Kent	Maple Valley
701 M ST NE #102	16720 SE 271st #200	27005 168th PL SE #200	8009 S180th ST #112	26837 Maple Valley Hwy #200
Auburn, WA 98002	Covington, WA 98042	Covington, WA 98042	Kent, WA 98032	Maple Valley, WA 98038
(253) 833-8766	(253) 630-5808	(253) 639-4788	(425) 226-7827	(425) 413-4425

OUTPATIENT PHYSICAL THERAPY

NAME:_______________________________**DATE:**_______________

FUNCTIONAL INDEX

Part I: Answer all 5 sections in **Part I.** Choose one answer in each section that best describes your conditions.

WALKING:
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk using a cane or crutches.
- ☐ I'm in bed most of the time & have to crawl to the toilet.

WORK: (applies to work in the home and outside)
- ☐ I can do as much work as I want to.
- ☐ I can do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

PERSONAL CARE: (washing, dressing, etc.)
- ☐ I can manage all personal care without symptoms.
- ☐ I can manage all personal care with some increased symptoms.
- ☐ Personal care requires slow, concise movements due to increased symptoms.
- ☐ I need help to manage some personal care.
- ☐ I need help to manage all personal care.
- ☐ I cannot manage any personal care.

SLEEPING:
- ☐ I have no trouble sleeping.
- ☐ My sleep is mildly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (3-5 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

RECREATION, SPORTS, LEISURE:
- ☐ I am able to engage in all my leisure activities without increased symptoms.
- ☐ I am able to engage in all my leisure activities with some increased symptoms.
- ☐ I am able to engage in most, but not all of my usual leisure activities because of increased symptoms.
- ☐ I am able to engage in a few of my usual leisure activities because of increased symptoms.
- ☐ I can hardly do any leisure activities because of symptoms.
- ☐ I can't do any leisure activities at all.

INDEX SCORE:

Functional________Pain________Improvement_______

UPPER EXTREMITY

Part II: Choose one answer that best describes your condition in the sections designated by your therapist.

CARRYING:
- ☐ I can carry heavy loads without increased symptoms.
- ☐ I can carry heavy loads with some increased symptoms.
- ☐ I cannot carry heavy loads overhead, but I can manage light/medium loads if they are positioned close to my body.
- ☐ I cannot carry heavy loads, but I can manage light to medium loads if they are conveniently positioned.
- ☐ I can carry very light objects with some increased symptoms.
- ☐ I cannot lift or carry anything at all.

DRESSING:
- ☐ I can put on a shirt or blouse without symptoms.
- ☐ I can put on a shirt or blouse with some increased symptoms.
- ☐ It is painful to dress, and I must be slow and careful.
- ☐ I need some help, but I can manage most of my dressing.
- ☐ I need help putting on a shirt or blouse.
- ☐ I can't put on shirt or blouse at all.

REACHING:
- ☐ I can reach to a high shelf and place a light object without increased symptoms.
- ☐ I can reach to a high shelf to a place a light object with some increased symptoms.
- ☐ I can reach to a high shelf to place an empty cup with a moderate increase in symptoms.
- ☐ I can't reach a high shelf to place a light object, but I can reach up to a lower shelf without increased symptoms.
- ☐ I can't reach to a lower shelf without increased symptoms, but I can reach counter-height to place a light object.
- ☐ I can't reach above my waist without increased symptoms.

LOWER EXTREMITY

STAIRS:
- ☐ I can walk stairs comfortably without a rail.
- ☐ I can walk stairs comfortably, but with a crutch, cane or rail.
- ☐ I can walk more than 1 flight of stairs with pain or weakness.
- ☐ I can walk less than 1 flight of stairs.
- ☐ I can manage only a single step or curb.
- ☐ I am unable to manage even a single step or curb.

UNEVEN GROUND:
- ☐ I can walk normally on uneven ground without loss of balance or using a cane or crutches.
- ☐ I can walk on uneven ground, but with loss of balance or with the use of a cane or crutches.
- ☐ I have to walk very carefully on uneven ground without using cane or crutches.
- ☐ I have to walk very carefully on uneven ground even using a cane or crutches
- ☐ I can walk very carefully on uneven ground using assistance.
- ☐ I am unable to walk on uneven ground

CERVICAL/TMJ

CONCENTRATION:

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with some difficulty.
- ☐ I can concentrate, but with moderate difficulty.
- ☐ I have a lot of difficulty when I try to concentrate.
- ☐ I have a great deal of difficulty when I try to concentrate
- ☐ I cannot concentrate at all.

HEADACHES:

- ☐ I do not experience headaches.
- ☐ I experience slight headaches (less than 3 weekly).
- ☐ I experience moderate headaches which come infrequently.
- ☐ I experience moderate headaches which come frequently.
- ☐ I experience severe headaches which come frequently.
- ☐ I experience headache pain almost constantly.

READING:

- ☐ I can read as much as I want with no increase in pain.
- ☐ I can read as much as I want with slight pain.
- ☐ I can read as much as I want with moderate pain.
- ☐ I cannot read as much as I want because moderate pain.
- ☐ I can hardly read at all because of severe pain.
- ☐ I am unable to read at all.

L/S, C/S, UPPER EXTREMITY

DRIVING:

- ☐ I can drive or travel without extra pain or discomfort.
- ☐ I can drive or travel in a car as long as I want with slight pain or discomfort.
- ☐ I can drive or travel in a car as long as I want with moderate pain or discomfort.
- ☐ I cannot drive or travel as long as I want because of moderate pain or discomfort.
- ☐ I can hardly drive or travel at all because of severe pain or discomfort.
- ☐ I cannot drive or travel at all.

LIFTING:

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it cause extra pain.
- ☐ Pain prevents me from lifting heavy weights but I manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights but I manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

TMJ

TALKING:

- ☐ I am able to talk without pain.
- ☐ I am able to talk as long as I want with slight pain in my jaw.
- ☐ I am able to talk as long as I want with mild pain in my jaw.
- ☐ I am unable to talk as long as I want because of mild pain in my jaw.
- ☐ I am hardly able to talk at all because of severe pain in my jaw.
- ☐ I am unable to talk at all.

EATING:

- ☐ I am able to eat whatever I want without pain.
- ☐ I am able to eat whatever I want but it causes extra pain.
- ☐ I am able to eat regular foods, but I try to avoid harder foods due to pain.
- ☐ Pain prevents me from chewing everything but soft foods.
- ☐ I am able to chew soft foods occasionally, but primarily adhere to a liquid diet.
- ☐ I am unable to chew or maintain a liquid diet due to pain.

L/S, LOWER EXTREMITY

STANDING:

- ☐ I am able to stand as long as I want.
- ☐ I am able to stand as long as I want, but it cause extra pain.
- ☐ Pain prevents me from standing for more than and hour.
- ☐ Pain prevents me from standing for more than a half hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SQUATTING:

- ☐ I am able to squat fully without the help of my arms, etc.
- ☐ I am able to squat fully, but with the help of my arms, etc.
- ☐ I am able to squat to ¾ of my normal depth.
- ☐ I am able to squat to ½ to ¾ of my normal depth.
- ☐ I am able to squat to ¼ to ½ of my normal depth.
- ☐ I am unable to squat any distance due to pain or weakness.

SITTING:

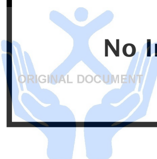
- ☐ I am able to sit in any chair as long as I like.
- ☐ I am able to sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than an hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

PAIN INDEX Please indicate on the scale below how much pain you are feeling at this time.

No Pain ________________________________ **Worst Pain Imaginable**

IMPROVEMENT INDEX Please indicate on the scale below your percentage of improvement since beginning PT.

No Improvement ________________________________ **Complete Improvement**


ORIGINAL DOCUMENT

Outpatient Physical Therapy

Auburn – Covington – Covington Satellite
Kent – Maple Valley

HEALTH HISTORY

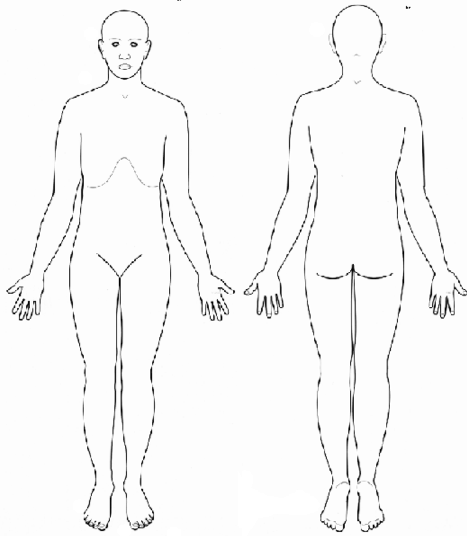
To insure that you receive a complete and thorough evaluation, please provide us with the most accurate, important, and up-to-date background information. Thank you.

Name: ________________________ Date:_____________

PRESENT CONDITION

Please briefly describe your symptoms: ________________
____
____

Please localize your **pain** or **abnormal** symptoms/sensations by marking on the body diagram below.



*When did you first notice symptoms:*__________________

Did you symptoms begin ***gradually*** *or* ***suddenly****? (circle one)*

How did your injury occur (if you have had surgery, please answer according to your pre-operative injury)::

- ☐ lifting
- ☐ a MVA (car accident)
- ☐ a fall
- ☐ overuse (cumulative trauma)
- ☐ degenerative process
- ☐ during recreation/sports
- ☐ other:_______________________________
- ☐ an impact injury
- ☐ a dental appointment
- ☐ throwing
- ☐ an incident at work
- ☐ unknown
- ☐ running

Since the onset of your condition, are your symptoms getting:

☐ better ☐ worse ☐ no change

Have you experienced similar symptoms in the past?

☐ yes ☐ no

More than one episode? ☐ yes ☐ no

Nature of pain/symptoms:

- ☐ aching
- ☐ constant
- ☐ dull
- ☐ occasional
- ☐ periodic
- ☐ sharp
- ☐ throbbing
- ☐ other

As your day progresses do your symptoms:

☐ increase ☐ decrease ☐ stay the same

Does the pain wake you at night? ☐ yes ☐ no

Since the onset of symptoms, have you experienced one of the following:

- ☐ difficulty controlling bowel or bladder function
- ☐ fever or chills
- ☐ any numbness in the genital or anal region
- ☐ numbness
- ☐ any dizziness or fainting attacks
- ☐ weakness
- ☐ unexplained weight change (loss or gain)
- ☐ night pain/sweats
- ☐ malaise (vague feeling of bodily discomfort)
- ☐ problems with vision/hearing

What aggravates your symptoms? (Check all that apply)

- ☐ sitting
- ☐ going to/rising from sitting
- ☐ lying down
- ☐ walking
- ☐ up/down stairs
- ☐ reaching overhead
- ☐ reaching in front of body
- ☐ reaching behind back
- ☐ reaching across body
- ☐ talking, chewing, yawning
- ☐ recreation or sports
- ☐ other ______________________________
- ☐ repetitive activities
- ☐ household activities
- ☐ standing
- ☐ squatting
- ☐ sleeping
- ☐ coughing/sneezing
- ☐ taking a deep breath
- ☐ looking up overhead
- ☐ swallowing
- ☐ stress
- ☐ sustained bending

What alleviates your symptoms? (Check all that apply)

- ☐ sitting
- ☐ heat
- ☐ cold
- ☐ stretching
- ☐ wearing a splint/orthosis
- ☐ rest
- ☐ standing
- ☐ walking
- ☐ exercise
- ☐ lying down
- ☐ massage
- ☐ medication
- ☐ other____________

What type of treatment have you sought for this condition?

- ☐ medication
- ☐ joint manipulation
- ☐ exercise
- ☐ massage therapy
- ☐ traction
- ☐ bracing/taping
- ☐ spinal injection
- ☐ muscle/skin injections
- ☐ chiropractor
- ☐ physical therapy
- ☐ biofeedback
- ☐ TENS unit
- ☐ other____________

Have you had any of the following tests for this condition?

- ☐ x-ray
- ☐ CT scan
- ☐ MRI
- ☐ arthrogram
- ☐ stress x-ray test (Telos)
- ☐ bone scan
- ☐ NCS (nerve conduction
- ☐ fluroscope
- ☐ vestibular
- ☐ other______________

Tests results: ____

MEDICATION

*Please list any and all **prescription** medication you are currently taking:* ____

____

____

*Dr. who prescribed the medication:*____________________

Are you currently taking any of the following over-the-counter medications:

- ☐ aspirin
- ☐ Tylenol
- ☐ corticosteroids
- ☐ antihistamines
- ☐ vitamins/mineral supplements
- ☐ Advil/Motrin/Ibuprofen
- ☐ other_____________________

GENERAL HEALTH

How would you rate your general health?

- ☐ excellent
- ☐ good
- ☐ average
- ☐ fair
- ☐ poor

Do you exercise outside of normal daily activities?

- ☐ 5+ days/week
- ☐ 3-4 days/week
- ☐ 1-2 days/week
- ☐ occasionally
- ☐ I do not work out

What do your athletic or recreational activities entail: ________

____

Do you smoke? ☐ yes ☐ no *packs per day:* _______

Are you pregnant? ☐ yes ☐ no *months:*_____________

MEDICAL HISTORY

Personal medical history:

- ☐ Cancer
- ☐ Depression
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Arthritis
- ☐ Head injury
- ☐ Stomach problems
- ☐ Parkinson's Disease
- ☐ Allergies
- ☐ fibromyalgia
- ☐ Infectious diseases:___________________________
- ☐ Heart Conditions
- ☐ High blood pressure
- ☐ Lung Problems
- ☐ Epilepsy/Seizures
- ☐ Mental/behavioral disorders
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Broken bone
- ☐ Circulation/vascular problems
- ☐ Skin diseases
- ☐ Other___________________

Have you been exposed to:

☐ HIV/AIDS ☐ Tuberculosis ☐ Hepatitis

Family or primary care physician: ________________________

Please list any recent/relevant surgeries or hospitalizations:

surgery/hospitalization date

____

____

____

Please list any major allergies (including medicine allergies):

____

____

____

Family medical history:

Has anyone in your immediate family ever been treated for one of the following?

- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Psychological condition
- ☐ Other____

I, the undersigned, state that I have answered this health history completely and to the best of my knowledge:

____

Signature

____

Date