PTSIR PATIENT INFORMATION

PLEASE PRINT

Name: ____________________________________ Date of Birth:_____________ Age:________

Address: __________________________________ Social Security # : ________________________________

City: __________________________ __________ State: _____ Zip Code:___________ Sex: M / F

Home#: ____________________ Cell#: _____________________ Work #:_____________________

Email address: ____

Emergency Contact Name: _____________________Relation:_____________________ Phone:__________________

PATIENT EMPLOYER INFORMATION

Employer:__________________________________ Job Title:______________________________________

Address:_____________________________ City:________________ State:________ Zip Code:_________

POLICY HOLDER INFORMATION

If you are NOT the policy holder listed on your insurance card, PLEASE complete the following:

Relationship to the Insured: Circle One Family Spouse Employee Other

Insured's Name:________________________________ Birth Date of Insured:__________________

Address:_______________________ City:________________ State:_______ Zip Code:_________

HOW DID YOU HEAR ABOUT PTSIR?

□ Physician □ Insurance Company □ Facebook/Social Media
□ Website □ Friend □ Previous Patient
□Advertisement; Please List:__________________________ □ Other:__________________________

INJURY INFORMATION

Date of Onset / Injury / Surgery: ___________________ State where injury took place: ______________________

Is this injury related to ? □ Work □ Car Accident □ Other Liability/Potential Lawsuit □ Not Applicable

Please read and Sign the following:

I hereby authorize release of any information, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, to the physician who referred me for therapy, and/or to any organization responsible for the payment of my account. I acknowledge and understand that I am responsible for all of the charges for services rendered to me by PTSIR Industrial Rehabilitation. Although I request that services be billed to the responsible organization on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason, any portion of my bill is not paid by the responsible organization, I further agree to make arrangements for prompt payment of the bill. I hereby authorize the responsible organization to pay the proceeds of any benefits due to me directly to PTSIR Industrial Rehabilitation. A copy of this can be considered as an original for insurance purposes and valid as an original. I hereby consent to such treatment procedures and patient care which in the judgment of my therapist, or physician, may be considered necessary or advisable while a patient at PTSIR Industrial Rehabilitation.

If you are unable to keep an appointment, we require that you provide PTSIR with a 24 hour notice. PTSIR has a $25.00 fee for all appointments canceled with less than a 24 hour notice or a no show. Insurance companies do not pay for this charge. Therefore you will be the party responsible for payment of the $25.00 cancellation fee. Your signature acknowledges and agrees to this cancellation policy.

Date:_________________ Signature:____

PTSIR PATIENT HISTORY QUESTIONNAIRE

PHYSICAL THERAPY AND SPORTS INJURY REHABILITATION

PERSONAL INFORMATION

I am currently: □ Employed □ Employed with restrictions □ On medical leave □ Not Employed

Interests/hobbies are: ____________________

Best way to reach me: □ Phone □ Email Address ____________________

Is there anyone who can assist you with doing home exercises or activities if needed? □ Yes □ No

Will you have any problems attending therapy sessions? □ No □ Yes, If yes, please describe ____________________

____

Next scheduled Dr. appointment: Date: ______________ Physician: ____________________

What is your MAIN complaint? ____________________

Please describe when and how your symptoms began: ____________________

____

GENERAL HEALTH

1. Activity Level: □ Low □ Medium □ High

2. Prior to your injury or illness, what activities could you do that you are unable to do now? ____________________

____

3. Are you aware of your diagnosis? □ Yes □ No 4. Are you aware of your prognosis? □ Yes □ No

5. Have you fallen in the last year? □ Yes □ No

6. CHECK ALL THAT APPLY:

	Chronic Back Pain		Visual Problems		Back Injury		Arthritis		Fracture
	Cancer □ In Remission		Kidney Disease		Skin Disease		Allergies		Hernia
	Stomach Disorders		Mental Illness		Lung Disease		Asthma		Diabetes
	Contagious Disease		Fainting Spells		Parkinson's		Epilepsy		Gout
	High Blood Pressure		Heart Disease		Pacemaker		Stroke		Head Injury
	Tingling or Numbness		Hearing Problems		Osteoporosis		Anxiety		

□ I CURRENTLY DO NOT HAVE ANY OF THE ABOVE CONDITIONS.

7. Do you have uncontrolled leakage of urine? □ Yes □ No 8. Do you have loss of bowel control? □ Yes □ No

9. Do you smoke? □ Yes □ No 10. Do you drink alcohol? □ Yes □ No

11. Are you on a special diet? □ Yes □ No 12. Any chance you are pregnant? □ Yes □ No

13. Please list current medications with dosages and their associated condition. □ Check if you have attached a list.

____________/____________ ____________/____________

____________/____________ ____________/____________

____________/____________ ____________/____________

14. Please list any prior surgeries or hospitalizations.

____

____

15. For patients 12 years or younger, is immunization/vaccination status current? □ Yes □ No

PERSONAL GOALS FOR THERAPY

16. What do you WANT to achieve from having therapy? Check all that apply:

□ Improve home activities □ Improve mobility/walking activities

□ Improve leisure/sports activities □ Decrease or eliminate pain/discomfort

□ Improve self-care activities □ Return to work: □ Current job □ Other job

17. Please include any additional information you feel would help us provide your care (ie. What you think would help; any apprehension about treatment; spiritual or cultural needs). ____________________

____

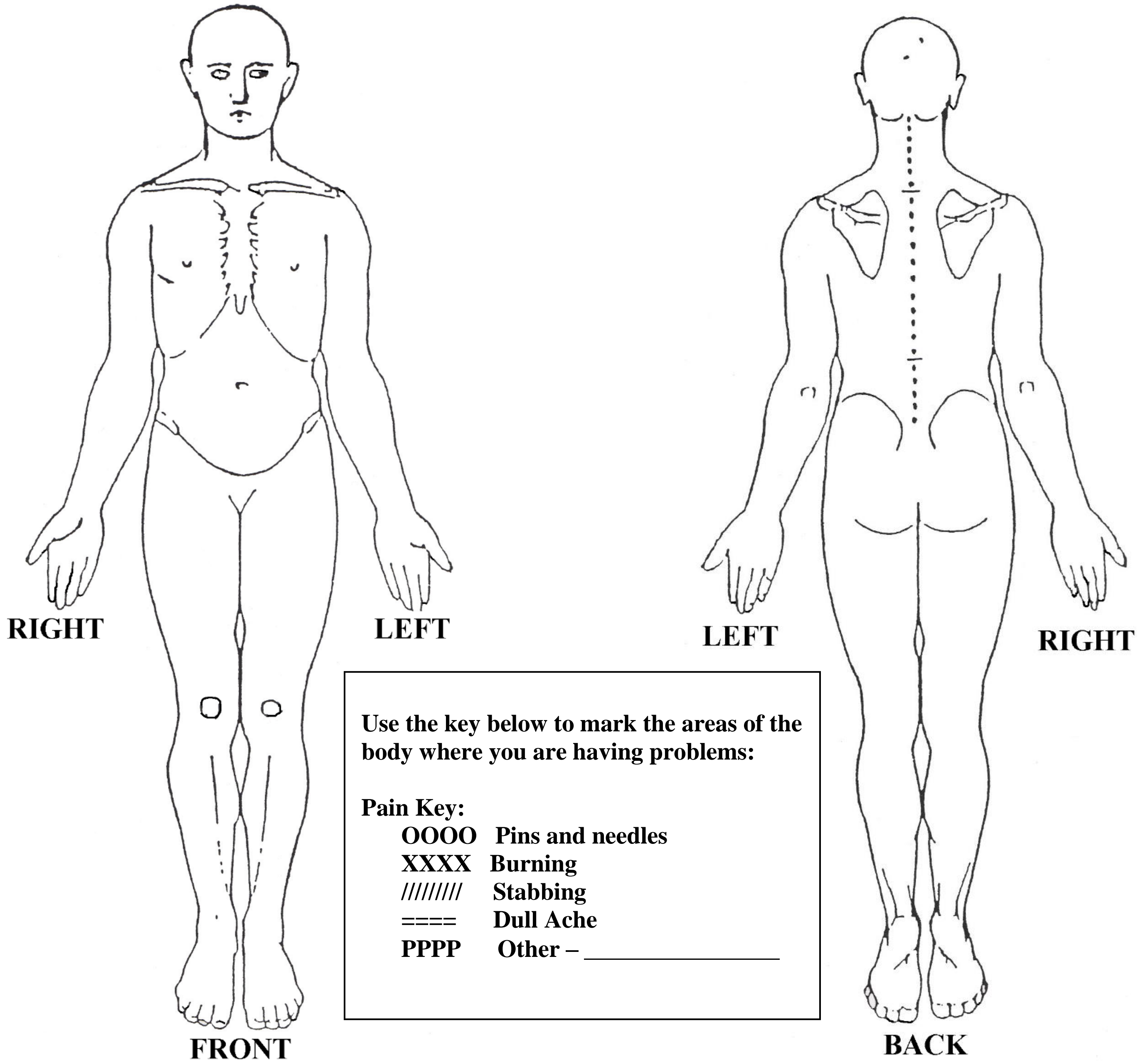
18. Please rate your pain level at rest: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

19. Please rate your pain with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

20. Is your pain (Please check all that apply): □ Increasing □ Decreasing □ Staying the same □ Occasional □ Constant

21. What increase your pain? ____

22. What decrease your pain? ____



Use the key below to mark the areas of the body where you are having problems:

Pain Key:

- **OOOO** Pins and needles
- **XXXX** Burning
- **/////////** Stabbing
- **====** Dull Ache
- **PPPP** Other – ________________

To the best of my knowledge, the above information is complete and factual.

____ ______________________________

Patient Signature **Date**

I consent to the use or disclosure of my protected health information by Physical Therapy and Sports Injury Rehabilitation (**PTSIR**) for the purpose of evaluating or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of **PTSIR**. I understand that evaluation or treatment of me by **PTSIR** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. **PTSIR** is not required to agree to the restrictions that I may request. However, if **PTSIR** agrees to a restriction that I request, the restriction is binding on **PTSIR**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **PTSIR** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **PTSIR**'s Notice of Privacy Practices prior to signing this document. **PTSIR**'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of **PTSIR**. The Notice of Privacy Practices for **PTSIR** is also provided at the receptionist desk. This Notice of Privacy Practices also describes my rights and **PTSIR**'s duties with respect to my protected health information.

PTSIR reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the **PTSIR** office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

Workers Compensation Information

Name: ______________________________________

Date of Injury: _________________________

Workers Compensation Insurance Company

Name: ____

Address: ____

Phone#: ____

Claim#: ____

Name of contact if any: ____

Attorney Information

Do you have an attorney representing you for this injury? Yes No

If yes, Please provide the contact information below.

Attorney name: ____

Attorney Phone#: ____