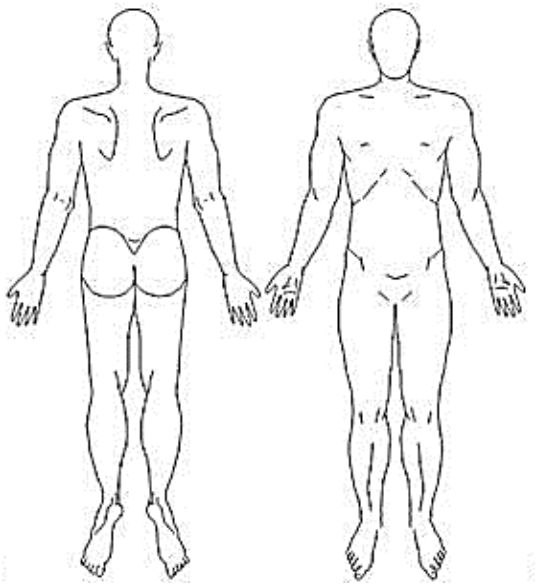
JACKSONVILLE PHYSICAL THERAPY

History of Presenting Condition

Name: _____ **Date**: _____

Reason for therapy:_____
_____

Please **shade in** areas of pain or abnormal sensation on **the body diagram**



When did symptoms begin?_____

Was the **onset**:
☐ Gradual ☐ Sudden

Have you **fallen**? How many and when?
_____

How did the injury/condition begin?
☐ Unknown ☐ During sport/recreation
☐ A fall ☐ Degenerative process
☐ At work ☐ Car accident
☐ Overuse
☐ Other _____

Are symptoms:
☐ Improving ☐ Not changing ☐ Worsening

Type of pain:
☐ Sharp ☐ Aching ☐ Dull ☐Throbbing
☐ Intermittent/Occasional ☐Constant
☐ Other _____

Throughout the day, do symptoms:
☐ Increase ☐ Decrease ☐ Stay the same

Does pain **wake you** at night?
☐ No ☐ Yes (when changing positions)
☐ Yes (when lying down)

Is pain/stiffness present when rising from bed?
☐ Yes ☐ No

Sleep **position**(s):
☐ Back ☐ Right side ☐ Left side
☐ Stomach ☐ Recliner

Do you have any of the following?
☐ Difficulty with bowel or bladder function
☐ Fever or chills
☐ Dizziness or fainting
☐ Night pain or sweats
☐ Problems with hearing or vision
☐ Numbness in the genitals or anal region
☐ Numbness
☐ Unexplained weakness
☐ Unexplained weight change

What **aggravates** your symptoms?
☐ Sitting ☐ Sustained bending
☐ Standing ☐ Squatting ☐ Sleeping
☐ Walking ☐ Cough/Sneeze ☐ Stairs
☐ Looking up ☐ Reaching overhead
☐ Lying down ☐Reaching across body
☐ Reaching up behind back
☐ Repetitive activity _____
☐ Household task _____
☐ Recreation/sport _____

What **eases** your symptoms?
☐ Sitting ☐ Standing ☐ Walking
☐ Lying down ☐ Stretching ☐ Exercise
☐ Rest ☐ Medication ☐ Massage
☐ Ice ☐ Heat ☐ Brace
☐ Other _____

JACKSONVILLE PHYSICAL THERAPY

History of Presenting Condition

Medications

List **prescription** medications you are taking:

_____

_____

☐ Provided separate medication list

Are you taking any **over the counter** medications?

☐ Aspirin ☐ Tylenol
☐ Ibuprofen/Advil/Motrin ☐ Antihistamines
☐ Vitamins/Supplements ☐Corticosteroids
☐ Other _____

Allergies

List any allergies: _____

Occupation

Job/Occupation: _____

☐ Full time ☐ Part time
☐ Self-employed ☐ Homemaker
☐ Student ☐ Retired
☐ Unemployed ☐ Other _____

Physical activities at work?

_____

Are you currently **receiving** or **seeking disability** for this condition? ☐ Yes ☐ No

If this is a work injury limiting your ability to perform your work activities, do you plan to **resume** your prior activity level? ☐ Yes ☐ No

Home/Living Environment

☐ Live alone ☐ Live with others
☐ Home/Apartment ☐ Assisted Living
☐ Stairs ☐ No Stairs
☐ Other _____

Family History

☐ No diseases/conditions

Condition	*Relation/Onset Age*
☐ Arthritis	_____
☐ Cancer	_____
☐ Diabetes	_____
☐ Heart Disease	_____
☐ Osteoporosis	_____
☐ Stroke	_____

Health History & Status

How is your **general health**?

☐ Excellent ☐ Average ☐ Good
☐ Fair ☐ Poor ☐ Other _____

What is your **function level?**

☐ Independent in all activities
☐ Independent in self-care (bathing, dressing)
☐ Difficulty with self-care
☐ Assistance needed with self-care
☐ Dependent for all activities

Do you **exercise** beyond normal activities?

☐ Yes (Days/week: _____) ☐ No
Exercise Type: _____

Alcohol Intake?

☐ None/Occasional ☐ Moderate ☐ Heavy

Smoking Status? (Tobacco/Marijuana)

☐ None/Occasional ☐ Moderate ☐ Heavy

Surgical History and Tests

☐ No Surgeries or Tests
☐ Shoulder _____ ☐ Knee _____
☐ Achilles _____ ☐ Hip _____
☐ Back _____ ☐ Neck _____
☐ Other: _____
☐ Other: _____

Have you had any **tests**?

☐ None ☐ X-rays ☐ Bone Scan
☐ CT Scan ☐ MRI ☐ Arthrogram
☐ Vestibular test (VNG, etc.)
☐ Other: _____

Medical History

Have you ever been diagnosed with:

☐ Arthritis ☐ Cancer
☐ Depression ☐ Diabetes
☐ Headaches ☐ Heart Problems
☐ Hepatitis ☐ High Blood Pressure
☐ HIV or AIDS ☐ Kidney Problems
☐ Lung Problems ☐ Osteoporosis
☐ Pacemaker ☐ Stroke
☐ Vascular/Circulatory Problems

Jacksonville Physical Therapy

MEDICATION LIST

Name:_____ Date:_____ Primary Doctor:_____

Additional Prescription Medications You Take

Name of Medicine & Strength (ex. Mg, units)	**How to take:** (ex: take 1 tablet by mouth 2x daily)	**Why are you taking this medicine?** Or comments:

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PATIENT REGISTRATION AND AUTHORIZATION

Name_____ Date of Birth_____/_____/_____
preferred phone #_____ other phone #_____Sex: M / F
email: _____ Marital status: S M W D (circle one)
Mailing Address_____City_____Zip_____
Social Security #_____ Employer_____
Emergency contact _____ phone # _____
Referring physician_____ Primary physician_____
Payment options (check one):
__1. I will be paying personally for my physical therapy treatments. (skip to the *Agreement* below.)
__ 2. Please bill my insurance company for payment. (Complete the following.)

→ If you have a card(s) for copying, complete only the name of your insurance(s).

***PRIMARY INSURANCE*_____ Phone_____**
Address _____City, State, Zip_____
Subscriber ID/Policy #_____ Group/Claim #_____
***SECONDARY INSURANCE* _____ Phone_____**
Address_____ City, State, Zip_____
Subscriber ID/Policy #_____ Group/Claim #_____
Are you the "subscriber"? Yes __ No __
If not, what is your relationship to the subscriber?
Spouse __ Child __ Other __ (explain) _____
Subscriber Name_____ Subscriber's Date of Birth ____/____/____

Is your injury a [ ]Worker's Compensation Claim, a [ ] Motor Vehicle Accident or a [ ]Personal Injury Claim? Date of injury ____/____/____
Do you have an attorney involved? If so, print your attorney's name, address and phone number.
Attorney name:_____ phone #_____ fax # _____
Attorney's address: _____
If WC, full name of employer_____
Insurance name _____ Phone # _____
Claim # _____
Claim Adjuster_____ Phone # _____
Send Claims to: _____ Fax # _____
_____
_____

Agreement:
I authorize payment to be made directly to Jacksonville Physical Therapy. I authorize release of my physical therapy case information to the above insurance companies, physicians and attorney, if applicable. I understand it is my responsibility to provide current and correct insurance information.

Patient's signature_____ Date_____

Guarantor's signature_____ Date_____

Jacksonville Physical Therapy

PRIVACY AND FINANCIAL POLICY STATEMENT

PRIVACY POLICY:

I understand that Jacksonville Physical Therapy (referred to below as "the clinic") will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my **health information** may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to/or consult and coordinate with other health care providers in the course of my treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care, including provision of medical supplies and equipment, and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

FINANCIAL POLICY:

You are responsible for payment of the fees for physical therapy services we provide to you. Co-pays are payable upon check-in. As a courtesy, we will bill your insurance company, but you are responsible for any fees your insurance does not cover. (If a check is returned by the bank, a fee will be charged to you.)

TO BE CERTAIN WHAT YOUR INSURANCE WILL COVER: please phone your insurance company and ask what physical therapy benefits your plan will pay to Jacksonville Physical Therapy.

If you have a concern about financial matters or questions about our usual fees, please feel free to ask us.

IF YOU ARE UNABLE TO ATTEND A SCHEDULED VISIT…

Please let us know as soon as you can. Missed appointments without notification or late cancellations, where we cannot fill the vacated appointment time, are a significant inconvenience to other patients, and we incur the cost of reserving that time for you.

For such missed appointments, you will be billed $50 personally. Your insurance company will not pay this fee.

By signing below, I agree that I have received or been offered a copy of this clinic's Notice of Privacy Practices, and agree to abide by the Financial Policy.

Patient's signature_____ Date_____

Guarantor's signature_____ Date_____

_____

_____

A copy of this policy has been given to the patient by: _____

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