



Patient Information Form

Patient to fill out highlighted sections

Appointment Date: _____ Time: _____ PT: _____ NP/ONP Acct #: _____
 Primary Care Physician: _____ Phone# _____
 Referring Physician: _____ Phone # _____
 Date Info Taken: _____ Emp. Initials: _____ Fin. Class: _____

(Patient to fill out.)

Patient Name: First _____ MI _____ Last _____
 Date of Birth: _____ Social Security # _____ Sex: _____ Marital Status: _____
 Phone # Home: _____ Work: _____ Cell: _____
 Current Address: _____ Apt. #: _____
 City: _____ State: _____ Zip: _____ E-mail _____
 Permanent Address: _____
 City: _____ State: _____ Zip: _____
 Employer: _____ Student: Full Time _____ Part Time _____
 Emergency Contact: _____ Relationship: _____ Phone#: _____
 Auto Related? Yes/No If Yes What State: _____ Work Related? Yes/No _____
 Date of Injury/Accident: _____ Date of Surgery: _____ Diagnosis: _____

(Office use only)

Primary INS: _____	Secondary INS: _____
Address: _____	Address: _____
Phone #: _____	Phone#: _____
Cardholder's Name/DOB/SS# : _____	Cardholder's Name/DOB/SS#: _____
Policy#, Claim#: _____	Policy#, Claim#: _____
Auth#: _____ Group#: _____	Auth#: _____ Group#: _____
Benefits: _____	Benefits: _____
Payor ID: _____ Payment Due: _____	Payor ID: _____ Payment Due: _____
Adj./NCM: _____ Fax#: _____	Adj./NCM: _____ Fax#: _____
Verified By: _____	Verified By: _____
Phone: _____	Phone: _____
Date: _____ Emp.Initials: _____	Date: _____ Emp. Initials: _____

**AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION &
AUTHORIZATION OF ASSIGNMENT OF BENEFITS**

We strongly feel that all patients deserve the very best medical care we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

PLEASE READ AND INITIAL THE FOLLOWING:

- I authorize this office to release or receive any information necessary to expedite insurance claims.
- I hereby authorize this office to bill my insurance company directly for their services.
- I authorize payment directly to this provider of my insurance benefits otherwise payable to me.
- In the event I receive payment from my insurance carrier, I agree to endorse any payment over to the provider for which these fees are payable.
- I hereby authorize the above physical therapist(s) to release information regarding services rendered by them and allow a photocopy of my signature to be used to file insurance. I hereby authorize the Tallahassee Orthopedic & Sports Physical Therapy to perform any service (evaluation, treatment procedures & testing) necessary for my rehabilitation.
- Tallahassee Orthopedic & Sports Physical Therapy is granted permission to release to the insurance carrier, employer, attorney, their representatives or referring physician, any information in connection with any treatment rendered to patient or patient's behalf at any time such information is requested.
- HIPAA – I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

I understand that I am directly & completely responsible to this provider for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover said fee. I realize that if my insurance carrier fails to pay my balance in full, or there is no payment made within 45 days, it is my responsibility to pay my balance directly. At 90 days, if no payment is made on my account interest will start accruing at 1 ½ % per month. I further understand & agree that if I fail to make timely payments on my account, I will be responsible for any & all-reasonable costs of collection including filing fees as well as reasonable attorney's fee.

A Photostat copy of these authorizations and agreements shall be as valid as original.

PATIENT OR GUARDIAN (PRINT)

PATIENT OR GUARDIAN SIGNATURE

DATE

All students must complete this section with a permanent address & the responsible party's information:

Responsible Party Name _____ Relationship _____

Address _____ City/State _____ Zip _____

Employer Name & Address _____ Phone _____

Reason why above is responsible _____



Health History Screening Form

Name: _____

Date: _____

Have you had surgery for your current condition? Yes No date if yes _____

Occupation _____ Are you working now Y N

Are you on a work restriction from your doctor? Y N Date last employed unrestricted _____

Do you smoke? Yes No Do you have a pacemaker? Yes No Are you pregnant? Yes No

ALLERGIES: List any medication(s) you are allergic to: _____

Do you have any open wounds or incisions? Yes No where? _____

Have you RECENTLY noted any of the following (check all that apply)?

- | | | |
|---|--|--|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> constipation |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> fainting |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough |
| <input type="checkbox"/> falls | <input type="checkbox"/> bowel or bladder incontinence | <input type="checkbox"/> headaches |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> lung problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> other arthritic condition | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke | <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> bone or joint infection | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> auditory disease | |

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots |

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? YES NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: Getting Better Getting Worse staying about the same

I should not do physical activities that might make my pain worse: Disagree Unsure Agree

Treatment received so far for this problem (chiropractic, injections, etc) _____

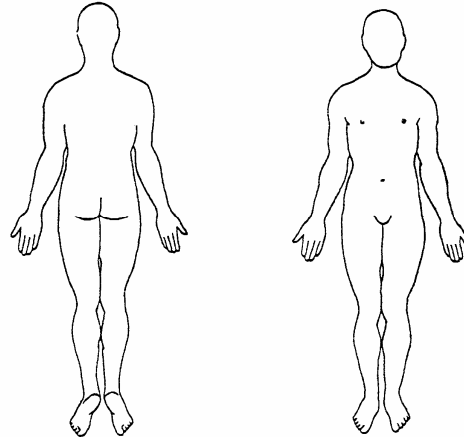
Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: Yes No When _____ Treatment rec'd _____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:



↓ Shooting/sharp pain

○ Dull/aching pain

||| Numbness

= Tingling

My symptoms currently: Come and go Are Constant Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

- 1. _____
- 2. _____
- 3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

- 1. _____
- 2. _____
- 3. _____

How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms the best? Morning Afternoon Evening Night After exercise

Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please circle:

Pain right this minute: 0 1 2 3 4 5 6 7 8 9 10

Worse Pain last 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Best pain last 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Reviewed by _____ Date _____

Therapist signature

Action needed Yes No Patient referred out Yes No Referred to: Called physician Sent to ER