

First Name: _____
Last Name: _____
Date of Birth: _____
Soc. Sec. #: _____



STRIVING TO REACH YOUR GOALS!!

Address	City	State	Zip
Home Phone	Sex M ◦ F	Age	Marital Status
Employer	Employer Address	Employer Phone	Occupation
Emergency Contact	Emergency Phone	Relationship	
Medical ◦ Workmans' Comp ◦ Motor Vehicle Accident			
Type of Injury (please circle)		Date of Injury	
Working Full Duty ◦ Working Light Duty ◦ Out of Work			
Work Status (please circle)		Date of surgery (if applicable)	

Primary Insurance:

Policy Holder:
Name: _____
Date of Birth: _____
Soc. Sec. #: _____
Relationship to patient:
SELF ◦ SPOUSE ◦ CHILD ◦ OTHER: _____

Secondary Insurance:

Policy Holder:
Name: _____
Date of Birth: _____
Soc. Sec. #: _____
Relationship to patient:
SELF ◦ SPOUSE ◦ CHILD ◦ OTHER: _____

Attorney Information (if you have an attorney involved, please provide their information in the following spaces):

Name: _____ Phone #: _____
Address: _____
Contact Person: _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO ACHIEVE PHYSICAL THERAPY, LLC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE ACHIEVE PHYSICAL THERAPY, LLC OR THE INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

Patient/Guardian Signature: _____ Date: _____

HEALTH HISTORY

Name: _____

Date of Birth: _____

X History of Current Problem:

- When did the problem(s) begin? (Please indicate date): _____
- What happened? _____
- Have you had this problem before? No Yes, (briefly explain) _____
- Did the problem get better? Yes No - How long did it last? _____
- How are you taking care of the problem? _____
- What makes the problem worse? _____
- What activities are you not able to do? (PLEASE BE SPECIFIC: 'Can't reach over my head': _____

- What are your goals for physical therapy? _____
 - Are you seeing anyone else for the problem(s)? (Please check all that apply):
- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Orthopedist |
| <input type="checkbox"/> Osteopath | <input type="checkbox"/> Dentist | <input type="checkbox"/> Pediatrician | <input type="checkbox"/> Family Practitioner |
| <input type="checkbox"/> Internist | <input type="checkbox"/> Neurologist | <input type="checkbox"/> OBGYN | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Podiatrist | <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Other: _____ |

X Current Limitation: (Please check all that apply):

- ___ BED MOBILITY (CHANGE POSITION IN BED) ___ TRANSFERS FROM BED TO CHAIR, CHAIR TO COMMODE
- ___ GAIT (WALKING): ___ ON LEVEL ___ ON STAIRS ___ ON RAMPS ___ UNEVEN TERRAIN
- ___ DIFFICULTY WITH SELF-CARE (BATHING, DRESSING, EATING, TOILETING)
- ___ DIFFICULTY WITH HOUSEHOLD: (CHORES, SHOPPING, DRIVING/TRANSPORTATION)
- ___ DIFFICULTY WITH COMMUNITY AND WORK ACTIVITIES ___ LIFTING ___ OUT OF WORK/SCHOOL
- ___ NO PARTICIPATION IN RECREATION/LEISURE ACTIVITIES ___ COMMUNICATION PROBLEM

X Home Environment:

- What type of home do you live in?
- | | | | | |
|------------------------------------|--|---|---|-----------------------------------|
| <input type="checkbox"/> One story | <input type="checkbox"/> More than one story | <input type="checkbox"/> Stairs with rail | <input type="checkbox"/> Stairs without railing | <input type="checkbox"/> Elevator |
|------------------------------------|--|---|---|-----------------------------------|
- With whom do you live? Alone Spouse only Family members Other: _____

X Medications: Please list ALL medications: _____

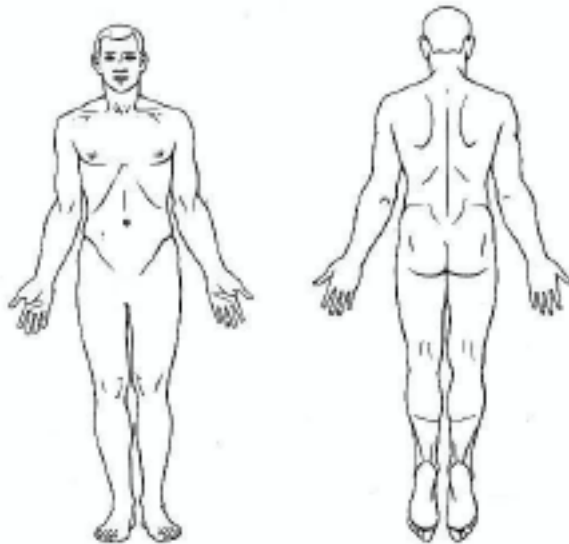
X Medical History: Please check if you have EVER had:

- ALLERGIES: () MEDICATION ◦ () FOOD ◦ () ENVIRONMENTAL ◦ () LATEX
- | | | | |
|----------------------------|--------------------------|-----------------------------------|-----------------------|
| ___ ARTHRITIS | ___ HIGH BLOOD PRESSURE | ___ BLOOD CLOTS | ___ SEIZURES/EPILEPSY |
| ___ KIDNEY PROBLEMS | ___ BLOOD DISORDERS | ___ JOINT SPRAINS | ___ SKIN DISEASE |
| ___ BROKEN BONES/FRACTURES | ___ LUNG PROBLEMS/ASTHMA | ___ EATING DISORDER | |
| ___ STROKE | ___ MULTIPLE SCLEROSIS | ___ MUSCLE/BONE DISEASE | ___ CANCER |
| ___ HEART ATTACK | ___ CIRCULATION/VASCULAR | ___ OSTEOPOROSIS | ___ DEPRESSION |
| ___ DIABETES | ___ PARKINSON'S DISEASE | ___ HEART ATTACK | ___ LOW BLOOD SUGAR |
| ___ THYROID PROBLEMS | ___ LEARNING DISABILITY | ___ HEART DISEASE | ___ HEPATITIS |
| ___ SUBSTANCE ABUSE | ___ INFECTIOUS DISEASE | ___ DEVELOPMENTAL/GROWTH PROBLEMS | |

OTHER _____

-Please list any surgeries. (Please include year): _____

X Please mark, on the drawings below, the areas where you feel pain:



X Pain Scale: On the line provided, please mark where you 'pain status' is today:

X-----**X**
No Pain Most Severe Pain



Patient Name: _____ Date of Birth: _____

X CONSENT FOR TREATMENT:

I GIVE MY CONSENT FOR ACHIEVE PHYSICAL THERAPY & FITNESS, LLC TO FURNISH PHYSICAL THERAPY TO MYSELF OR DEPENDANT THAT IS CONSIDERED NECESSARY AND PROPER FOR TREATMENT OF MYSELF OR DEPENDANT'S PHYSICAL CONDITION.

INITIALS: _____

X ASSIGNMENT OF BENEFITS:

I AUTHORIZED PAYMENT OF MEDICARE / INSURANCE BENEFITS TO BE MADE DIRECTLY TO ACHIEVE PHYSICAL THERAPY & FITNESS, LLC ON MY BEHALF FOR PHYSICAL THERAPY SERVICES RENDERED. I AUTHORIZE ACHIEVE PHYSICAL THERAPY & FITNESS, LLC TO RELEASE MY PROTECTED HEALTH INSURANCE FOR TREATMENT AND BILLING PURPOSES.

INITIALS: _____

X NOTICE OF PRIVACY PRACTICES:

I HAVE RECEIVED A WRITTEN COPY OF ACHIEVE PHYSICAL THERAPY & FITNESS, LLC NOTICE OF PRIVACY PRACTICES. THE NOTICE PROVIDES, IN DETAIL, THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT MAY BE MADE BY ACHIEVE PHYSICAL THERAPY & FITNESS, LLC, MY RIGHTS AS THE PATIENT, AND ACHIEVE PHYSICAL THERAPY & FITNESS, LLC LEGAL DUTIES WITH RESPECT TO MY PROTECTED HEALTH INFORMATION.

INITIALS: _____

X FINANCIAL POLICY:

AS A COURTESY, ACHIEVE PHYSICAL THERAPY & FITNESS, LLC WILL PRE-VERIFY YOUR INSURANCE BENEFITS. PLEASE NOTE: UNLESS YOU HAVE SECONDARY INSURANCE, ALL CO-PAYS, DEDUCTIBLES, AND / OR CO-INSURANCE IS THE RESPONSIBILITY OF THE PATIENT, PARENT OR GUARDIAN OF A DEPENDANT. CO-PAYS ARE DUE AT THE TIME SERVICES ARE RENDERED. YOUR DEDUCTIBLE / CO-INSURANCE WILL BE BILLED TO YOU WHEN WE RECEIVE AND 'EXPLANATION OF BENEFITS (EOB)' FROM YOUR INSURANCE CARRIER. YOU ARE ENCOURAGED TO OBTAIN THE DETAILS OF YOUR PLAN'S EXACT COVERAGE FOR VERIFICATION.

PAYMENT METHODS INCLUDE: CASH, CHECK, MONEY ORDER AND CREDIT CARD. CREDIT CARD PAYMENTS INCUR A 3% PROCESSING FEE

X CANCELLATION / NO-SHOW POLICY:

ACHIEVE PHYSICAL THERAPY & FITNESS, LLC URGES YOU TO KEEP EVERY APPOINTMENT, AS CONSISTENT TREATMENT WILL PROMOTE A SPEEDY RECOVERY. WE REQUIRE 24 HOURS IF YOU NEED TO CANCEL AN APPOINTMENT. PATIENTS WHO CANCEL WITHOUT PROPER NOTICE OR FAIL TO SHOW UP FOR SCHEDULED APPOINTMENTS WILL BE SUBJECT TO A \$25.00 CHARGE.

INITIALS: _____

SIGNATURE ON FILE:

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE POLICIES AND PROCEDURES.

PATIENT SIGNATURE

DATE

WITNESS

DATE