PERFORMANCE PHYSICAL THERAPY

Please Print Clearly

Patient Registration

Patient Name: _____ Birth Date: _____ Gender: M F
Last First MI

Address: _____
Street/PO Box Apt # City State Zip+4

Employer: _____ Social Security # _____-_____-_____

Phone: ( ) _____ Cell phone: ( ) _____ Work Phone: ( ) _____

Appointment Reminders: Our office does not make Appointment Reminder telephone calls. However you may choose to receive Appointment Reminders by text message or by email. Please indicate one choice below:

- ☐ Text message reminder to the above cell phone number. My cell phone carrier is : _____
  I recognize that normal text messaging rates may apply.
- ☐ Email reminder to this email address: _____

Parent (if **minor** or **college student**)/Responsible Party Name: _____ Date of birth _____

Address: _____ Phone ( ) _____
Street City State Zip

REASON FOR VISIT/Area of body to be treated: _____ Date of onset: _____ Date of surgery: _____

Primary Physician: _____ **Referring Physician:** _____

HEALTH INSURANCE INFORMATION

Primary Insurance: _____ Subscriber's Name: _____ Subscriber's Birth date _____

Consumer/Subscriber# _____ Group Plan # _____ Co Pay _____

Secondary Insurance: _____ Subscriber's Name: _____ Subscriber's Birth date _____

Consumer/Subscriber# _____ Group Plan # _____

ACCIDENT INFORMATION

MOTOR VEHICLE ACCIDENT, Date of injury: _____
In Washington State? Yes No If No, where? _____
PIP Insurance: _____
Claim#: _____
PIP Adjuster: _____
Phone: _____

If you have consulted an attorney, please provide:
Attorney Name: _____
Phone #: _____

WORK RELATED INJURY, Date of injury: _____

Employer at time of injury: _____
Have you received previous Physical Therapy for this claim?
Yes No If yes, where? _____
Washington State L&I Claim #: _____

If self-insured Workman's Comp,
Name of Company: _____
Address: _____
Phone#: _____
Adjuster: _____

Please sign CONSENT and RELEASE on Reverse

Staff _____ Eval Date _____ Therapist _____ Revised 12/13

Consent to Treat and Authorization to Bill Insurance

I consent to treatments and authorize use of this signature for the release of medical information necessary to process all claims with my insurance company. Performance Physical Therapy (PPT) will bill my insurance company directly and I authorize direct payment of benefits to PPT. I understand it is my responsibility to know my healthcare benefits, its limits and non-covered items. I will keep Performance Physical Therapy informed of any changes to my insurance coverage. I will be personally responsible for any copays, deductible, or non-covered balances remaining after insurance consideration. I understand that my insurance requires that copays are made at the time of each visit.

If I choose to receive Appointment Reminders by text messaging, normal text messaging rates may apply.

I also understand that any email communication that I may agree to receive is not sent in an encrypted format.

_____ Date: _____

Signature of Patient or responsible party (if patient is a minor)

"NOTICE OF PRIVACY PRACTICES"

Law requires us to make a good faith effort to obtain your signature signifying you have been offered a copy of our Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. The Notice provides a description of our treatment, payment, healthcare operations, and the uses and disclosures we may make of your Protected Health Information. It explains in detail the procedures we use to protect your healthcare and personal information. Please take the time to read it carefully and completely.

"By my signature below I acknowledge receipt of the Notice of Privacy Practices. I also understand that I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations."

_____ _____

Patient or legally authorized individual signature Date Time

MEDICARE PATIENTS: PLEASE COMPLETE THIS SECTION

LIFETIME AUTHORIZATION

Provider: Performance Physical Therapy, Inc.
2075 Barkley Blvd, Suite 200, Bellingham, WA 98226 **OR**
1616 Cornwall Ave, Bellingham, WA 98225

Patient's Name: _____

Patient's Medicare #: _____

Patient's Address: _____

_____

This authorization is good until revoked/rescinded by patient.

I request that payment under the medical insurance program be made to the provider named above on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Date: _____ Patient's Signature: _____

MEDICAL HISTORY FORM PERFORMANCE PHYSICAL THERAPY

Please check if you have, or have had, any of the conditions listed below:

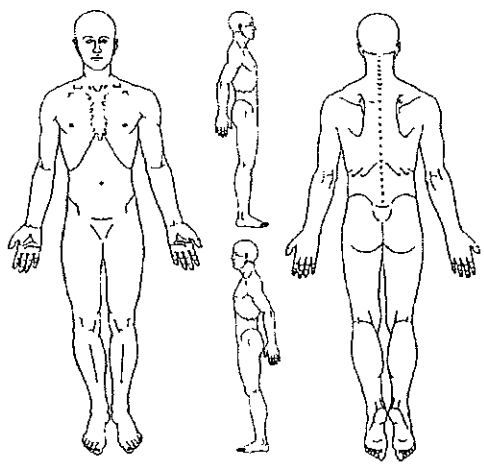
Allergies	Yes ☐ No ☐	Depression	Yes ☐ No ☐	Multiple sclerosis	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Osteoporosis	Yes ☐ No ☐
Anxiety	Yes ☐ No ☐	Dizzy spells	Yes ☐ No ☐	Parkinson's	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Emphysema/Bronchitis	Yes ☐ No ☐	Rheumatoid arthritis	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Fractures	Yes ☐ No ☐	Seizures	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Gallbladder problems	Yes ☐ No ☐	Speech problems	Yes ☐ No ☐
Cardiac Conditions	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐	Strokes	Yes ☐ No ☐
Cardiac Pacemaker	Yes ☐ No ☐	High blood pressure	Yes ☐ No ☐	Thyroid disease	Yes ☐ No ☐
Chemical Dependency	Yes ☐ No ☐	Incontinence	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Circulation Problems	Yes ☐ No ☐	Kidney problems	Yes ☐ No ☐	Vision problems	Yes ☐ No ☐
Currently Pregnant	Yes ☐ No ☐	Metal Implants	Yes ☐ No ☐		

Describe any other conditions or precautions:

_____

_____

_____



Please mark on the diagram the location of your pain.

Fall History:

Are you seeing us as a result of a fall in the past year? Yes ☐ No ☐

Have you had two or more falls in the past year? Yes ☐ No ☐

Surgical History:

List past surgeries, and approximate dates of surgeries:

_____

_____

_____

_____

_____

Current Medications:

List current medications, dosage and reason for taking the medication.

_____

_____

_____

_____

Do you have a follow up appointment scheduled with the Doctor who referred you to our clinic? Yes ☐ No ☐

If so, when? _____

Completed by: _____ Signature _____ Date _____

(Printed name) (Patient's signature)

Initials _____ Date _____	Initials _____ Date _____	Initials _____ Date _____	Initials _____ Date _____	Initials _____ Date _____	Initials _____ Date _____

CARE CONNECTIONS

CERVICAL/THORACIC

NAME _____ DATE _____

TIME _____ AM/PM ☐ Initial Visit ☐ Discharge Visit

FUNCTIONAL INDEX

Choose the one answer in each section that best describes your condition.

WALKING

- ☐ Symptoms do not prevent me walking any distance.
- ☐ Symptoms prevent me walking more than 1 mile.
- ☐ Symptoms prevent me walking more than 1/2 mile.
- ☐ Symptoms prevent me walking more than 1/4 mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

WORK

(Applies to work in home and outside)

- ☐ I can do as much work as I want to.
- ☐ I can only 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 (only light duty).
- ☐ 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 (2–3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3–5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5–7 hrs. sleepless).

RECREATION/SPORTS

(Indicate Sport if Appropriate _____)

- ☐ I am able to engage in all my recreational/sports activities without increased symptoms.
- ☐ I am able to engage in all my recreational/sports activities with some increased symptoms.
- ☐ I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
- ☐ I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
- ☐ I can hardly do any recreational/sports activities because of increased symptoms.
- ☐ I cannot do any recreational/sports activities at all.

CONCENTRATION

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come less than 3 per week.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come 4 or more per week.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all of the time.

READING

- ☐ I can read as much as I want without increased symptoms.
- ☐ I can read as much as I want with slight symptoms.
- ☐ I can read as much as I want with moderate symptoms.
- ☐ I cannot read as much as I want because of moderate symptoms.
- ☐ I can hardly read at all because of severe symptoms.
- ☐ I cannot read at all.

DRIVING

- ☐ I can drive my car or travel without any extra symptoms.
- ☐ I can drive my car or travel as long as I want with slight symptoms.
- ☐ I can drive my car or travel as long as I want with moderate symptoms.
- ☐ I cannot drive my car or travel as long as I want because of moderate symptoms.
- ☐ I can hardly drive at all or travel because of severe symptoms.
- ☐ I cannot drive my car or travel at all.

LIFTING

- ☐ I can lift heavy weights without extra symptoms.
- ☐ I can lift heavy weights, but it gives extra symptoms.
- ☐ My symptoms prevent me from lifting heavy weights, but I manage if they are conveniently positioned (e.g. on a table).
- ☐ My symptoms prevent 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.

ACUITY *(Answer on initial visit.)*

How many days ago did onset/injury occur? _____ days

Please complete opposite side

PAIN INDEX

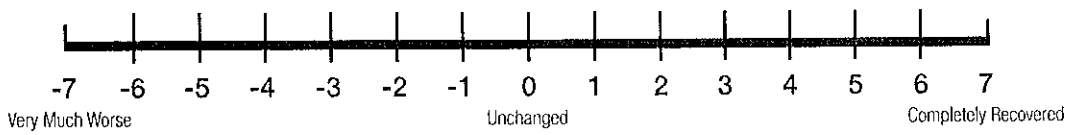
Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain ——————————————— Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

GLOBAL RATING OF CHANGE

With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic? (Circle one)



■ WORK STATUS *(check most appropriate)*

1. ❒ No lost work time
2. ❒ Return to work without restriction
3. ❒ Return to work with modification
4. ❒ Have not returned to work
5. ❒ Not employed outside the home

Work days lost due to condition:_____ days

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial: _____