PREMIER
PHYSICAL THERAPY

Patient Case #: _____

16261 Redmond Way Ste 100 ● Redmond, WA 98052 ● PH 425-881-3001 ● FAX 425-881-3585 ● www.PremierSportsRehab.com
12911 120th Ave NE Suite F-120 Kirkland, WA 98034 ● PH: 425.305.2940 ● FAX: 425.305.2941

Confidential Patient Information

(Please Fill Out Completely)

Full Name:_____ _____ _____ Preferred Name:_____
First M.I. Last

Address:_____ _____ _____ _____
Street City State Zip Code

D.O.B.:_____/_____/_____ Age:_____ Sex: ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ D ☐ W

Home Phone:_____ Cell Phone:_____ Work Phone:_____
Primary/Secondary/Tertiary Primary/Secondary/Tertiary Primary/Secondary/Tertiary

Email Address:_____

Emergency Contact: Name:_____ Relation:_____ Phone _____

Employment Status: ☐ Student ☐ Working ☐ Retired ☐ Homemaker ☐ Unemployed

Employer:_____ Type of Work:_____
*Required for L&I claims

Injury/Onset of Pain Information

Date of Injury/Onset:_____/_____/_____ Date of Surgery:_____/_____/_____ Job Related? ☐ Y ☐ N
*Mandatory to trigger insurance coverage Auto Accident? ☐ Y ☐ N

If yes, is an attorney involved? ☐ Y ☐ N Name & Phone:_____

Injured Region(s) of Body:_____

Referring Physician:_____ Primary Care Physician:_____

Are you aware of your diagnosis and prognosis as explained by your doctor?: ☐ Y ☐ N

Whom may we thank for this referral?:_____
Relation: Please circle all that apply: Doctor Friend Family Google Bing

Appointment Reminders

(Please Choose Only <u>One</u>)

How would you like your reminders? ☐ Email ☐ Phone ☐ Text Message ☐ None

If you have checked <u>Text Message</u>, who is your <u>Cell Phone Provider</u>?:_____

<u>Patient, or Parent/Guardian (if under 18 years old)</u>

Signature:_____Date:_____/_____/_____

Patient Case #: _____

Consent for Treatment

I agree to give my consent for *Premier Physical Therapy Inc.* to furnish rehabilitation services considered necessary and proper in the treatment for my physical condition.

Disclosure of Medical Records & Information Privacy Statement

Premier Physical Therapy Inc. will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility, on our website, and have copies available for distribution upon request. The undersigned acknowledges receipt of this information. I authorize *Premier Physical Therapy Inc.* to release copies of the physical therapy record and billing statements to my insurance company for the purpose of billing for the services rendered.

Financial Liability

Your health insurance plan is a contract between you and the insurance company. We are not party to the contract.
Premier Physical Therapy will bill your insurance carrier out of courtesy and as a convenience for you. However, you are ultimately responsible for payment for the services you receive. If your insurance company remits only a percentage of the total balance due, you will be responsible for the remainder of the balance. **Co-Pays are always due at the time of service as described in your insurance policy**. As a courtesy our office staff will verify insurance coverage, but this is not a guarantee. **It is the patient's responsibility to confirm benefits with their insurance company prior to the first physical therapy appointment.**

Balances unpaid after 60 days must have payment arrangements with our billing office. Balances unpaid after 91 days will be turned over to our collection agency. Checks returned with non-sufficient funds will be charged a $25.00 fee.

Cancelation/ No-Show Policy

All appointments scheduled represent time set aside specifically for you, therefore arriving more than 15 minutes late may be considered a no-show at the therapist's discretion. If you no-show you are required to confirm all future appointments, otherwise it will result in cancelation. By law, all cancelations and no-shows involving worker's compensation claims must be reported to your physician and your claims adjuster. **All cancellations less than 24 hour notice and no-show appointments will be charged a fee of $50.00 to your account. This fee is due before or at the time of your next physical therapy visit. Cancellations due to illness or family emergency are excluded from this policy, however notification is required.**

I understand and agree to the sections described above: *Consent for Treatment*, *Disclosure of Medical Records & Information Privacy Statement*, *Financial Liability*, and *Cancelation/No-Show Policy*.

Signature of Patient, or Parent/Guardian (if under 18 years old)

_____ **Date: ___/___/___**

Patient Case #: _____

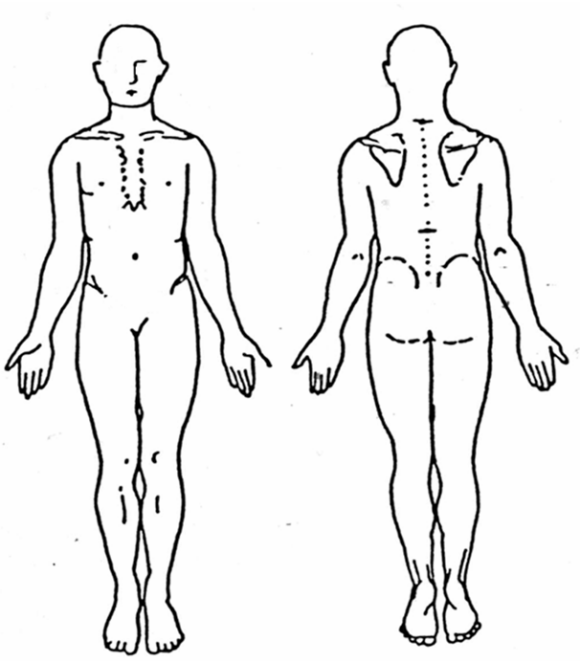
History of Present Condition

Function & Symptom Questionnaire

Are your symptoms:

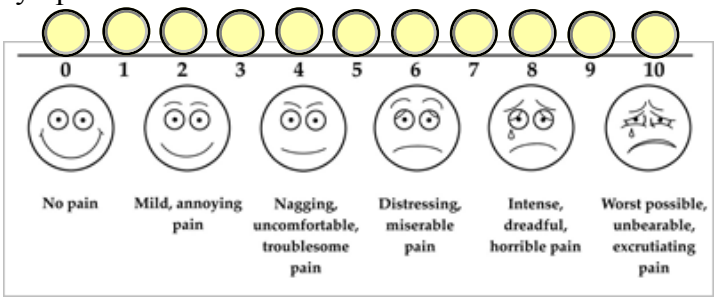
- ☐ improving
- ☐ becoming worse
- ☐ staying the same

Please circle or mark painful or injured areas:



Visual Analogue Scale

Please indicate the average intensity of your symptoms:



Exercise

What is your activity/exercise level? How many days per week do you perform physical activity? Please describe:

_____

_____

_____

Symptoms

What aggravates your symptoms?

- ☐ sitting
- ☐ lying down
- ☐ walking/running
- ☐ up/down stairs
- ☐ reaching overhead
- ☐ lifting objects
- ☐ playing a sport
- ☐ repetitive activities
- ☐ standing
- ☐ bending forward
- ☐ sleeping
- ☐ coughing/sneezing
- ☐ turning/twisting body
- ☐ sustained movements
- ☐ stress
- ☐ other: _____

Does anything relieve your symptoms? Please explain:

_____

_____

_____

_____

Medications

Please list any current medications, including over the counter and supplements: _____

_____

_____

_____

_____

_____

_____

Past and Current Treatments/Tests

Region of the body and date

- ☐ Physical Therapy _____
- ☐ Massage Therapy _____
- ☐ Chiropractic Care _____
- ☐ Home Health Care _____
- ☐ Emergency Room Care _____
- ☐ Hospitalization _____
- ☐ Ergonomics Evaluation _____
- ☐ Acupuncture _____
- ☐ CT Scan _____
- ☐ MRI _____
- ☐ Bone Scan _____
- ☐ X-Rays _____
- ☐ Medication/Injection _____
- ☐ Other _____

_____

Patient Case #: _____

History of Present Condition Continued…

Medical History

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Lung problems
- ☐ Cardiovascular disease
- ☐ Blood clot/Embolism
- ☐ Varicose veins
- ☐ Chest pain/Angina
- ☐ Pacemaker
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ Seizures/Epilepsy
- ☐ Weight loss (significant)
- ☐ Fatigue
- ☐ Weakness
- ☐ Loss of balance/falls
- ☐ Dizziness/Fainting
- ☐ Visual difficulties
- ☐ Hearing difficulties
- ☐ Headaches/Migraines
- ☐ Nausea/Vomiting
- ☐ Neurological deficits
- ☐ Sleep difficulties
- ☐ Depression
- ☐ Eating disorders
- ☐ Chemical dependency
- ☐ Pregnant (current/post-partum)
- ☐ Bowl/Bladder issues
- ☐ Thyroid disease
- ☐ Goiter
- ☐ Diabetes
- ☐ Anemia
- ☐ Hypoglycemia
- ☐ Infectious disease
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Hernia
- ☐ Cancer
- ☐ Joint injury: _____
- ☐ Chronic pain
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Broken bones/fractures
- ☐ Pain with sneezing
- ☐ Allergies: latex/adhesives/lotions
- ☐ Sensitivity to heat/ice
- ☐ Other: _____

Surgery

Please list any previous surgeries (e.g. metal implants, joint replacements, heart surgeries, etc.): _____

Expectations

What are your rehabilitation expectations and goals in this program other than pain reduction? _____

Other

Please list any other information that you believe would assist the therapist in your care: _____

Medicare Patients

Height: _____ Weight: _____ *mandatory for reporting BMI to medicare

I, the undersigned, certify that the above information described in *History of Present Condition* is true to the best of my knowledge.

Signature of Patient, or Parent/Guardian (if under 18 years old)

_____ **Date: ___/___/___**