16261 Redmond Way Suite 100 ● Redmond, WA 98052 ● PH 425-881-3001 ● FAX 425-881-3585 ● redmond@premiersportsrehab.com ● www.premiersportsrehab.com

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:_____/_____/____

Disclosure of Medical Records & Information Privacy Statement

Redmond Physical Therapy Inc. (Premier PT) 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. A detailed NOTICE OF PRIVACY PRACTICES is available at our facility, on our website, and is available for distribution upon request. The terms of this notice may change with time. The undersigned acknowledges receipt of this information, and authorizes *Premier PT* to release copies of the physical therapy record and billing statements to the patients' insurance company for the purpose of billing for services rendered. The undersigned also allows us to communicate with them *via email*, regarding this personal health information and billing.

Financial Liability

As a courtesy, *Premier PT* will verify your insurance coverage and bill your insurance carrier, however you are ultimately responsible for payment for the services you receive. **Your health insurance plan is a contract between you and the insurance company - Premier PT is not party to the contract. It is your responsibility to confirm benefits with your insurance company prior to the first physical therapy appointment.** 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**.

Statements for any balance owed are mailed out monthly. Balances unpaid after 60 days must have payment arrangements with our clinic, and any amount unpaid after 91 days may be turned over to our collections agency. Checks returned with non-sufficient funds will be charged a $25.00 fee.

Cancellation/ 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 future appointments, otherwise they may be cancelled. **All cancellations with less than 24 hour notice and all no-show appointments will be charged a fee of $50.00. This fee is <u>not</u> payable by your insurance and 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**.** Note that for worker's compensation claims, we may be obligated to report missed appointments to your adjuster / insurer.

I understand and agree to the sections described above: *Disclosure of Medical Records & Information Privacy Statement*, *Financial Liability*, and *Cancellation/No-Show Policy*.
I also give my consent for *Redmond Physical Therapy Inc.* to furnish rehabilitation services considered necessary and proper in the treatment of my physical condition.

_____

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

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

PREMIER PHYSICAL THERAPY

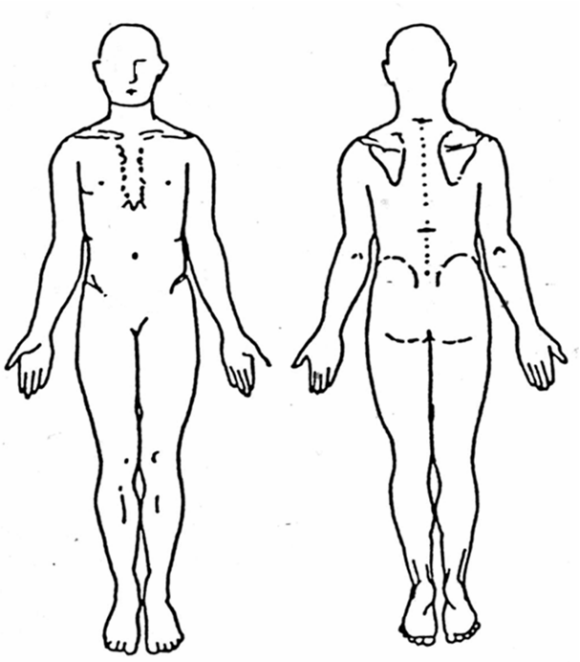
History of Present Condition

Function & Symptom Questionnaire

Are your symptoms:

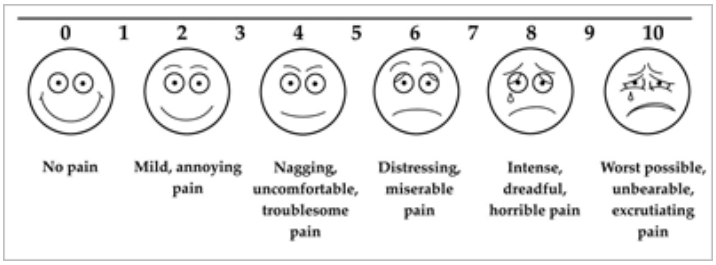
- ☐ improving
- ☐ becoming worse
- ☐ staying the same

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? 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
- ☐ sustained movement
- ☐ 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 _____

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)
- ☐ Bowel/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: _____

_____

_____

_____

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: ___/___/___**