

**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 One)

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

If you have checked Text Message, who is your Cell Phone Provider?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_**

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***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 not 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.

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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:  \_\_\_/\_\_\_/\_\_\_



***History of Present Condition***

**Function & Symptom Questionnaire**

Are your symptoms:

improving

becoming worse

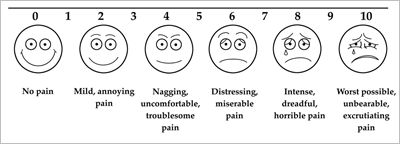
staying the same

*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  standing

lying down  bending forward

walking/running  sleeping

up/down stairs  coughing/sneezing

reaching overhead  turning/twisting

lifting objects  sustained movement

playing a sport  stress

repetitive activities  other: \_\_\_\_\_\_\_\_\_\_

Does anything relieve your symptoms? Please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Height \_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_**

**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: \_\_\_/\_\_\_/\_\_\_**