ENEA Physical Therapy + Wellness

Physical Therapy Patient Information

Today's Date: ___/___/_____

Patient Name: _____ Sex: ____ DOB: ___/___/_____
If Minor, Parent or Legal Guardian Name: _____
Name of Insured (if not patient): _____ Relationship: _____
Phone Number: _____ DOB: ___/___/_____
Patient Mailing Address: _____ Height: _____ Weight: _____
City, State, Zip: _____ Social Security: ___/___/_____
Phone (Home): _____ (Work): _____ (Cell): _____
Email Address: _____
Marital Status: _____ Occupation: _____ Employer: _____
Current Work Status: FT __ PT __ Restricted Duty ___ Retired ___ Out of Work (since? _____)
Emergency Contact: _____ Phone: _____
Primary Care Physician: _____ Complaint/Injury: _____
Have you had Physical Therapy for any reason this year? Yes ____ No ____
If Yes, please explain: _____
How did you hear about our office? _____

Accident Information (Please check one of the following)

1. Were you injured while at work? _____ Date of Injury: ___/___/_____
   Have you received prior treatment? _____ If yes, with whom: _____
   Workman's Compensation Agent: _____
   Phone Number: _____ Claim Number: _____
   Name of Attorney (if applicable): _____ Phone: _____
   Address: _____
   Dates out of work: ___/___/_____ to ___/___/_____
   *****If this injury occurred at work, please complete the employer information above*****

2. Automobile accident? _____ Date of Accident: ___/___/_____
   Have you received prior treatment? _____ If Yes, name of physician: _____
   Automobile Insurance Carrier: _____ Claim Number: _____
   Name of Adjuster: _____ Phone: _____
   Name of Attorney (if applicable): _____ Phone: _____
   Address: _____
   State accident occurred in: _____Who was at fault? _____
   Dates out of work: ___/___/_____to ___/___/_____

PLEASE BE SURE TO PROVIDE ALL INFORMATION REGARDING YOUR INSURANCE COVERAGE, ESPECIALLY IF YOU ARE COVERED BY MORE THAN ONE POLICY. THANK YOU!

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Medical History Questionnaire

Patient Name: _____ DOB: ____/____/____

Reason for today's visit: _____

Are you currently receiving any other care for this injury: □ NO □ YES _____

Have you had physical therapy for this condition before? □ NO □ YES _____

Have you had physical therapy for a different condition this year? □ NO □ YES _____

Could you be pregnant? □ NO □ YES

Is this a work related injury or due to a motor vehicle accident? □ NO □ YES _____

Do you currently have or have you had any of the following?		
□ Arthritis	□ Diabetes	□ Thyroid Problem
□ Osteoporosis	□ Anemia	□ Headaches
□ High Blood Pressure	□ Hypersensitivity to Hot / Cold	□ Head Injury / Concussion
□ Heart Disease	□ Swelling in Ankles	□ Hernia
□ Heart Attack	□ Deep Vein Thrombosis (DVT)	□ Kidney / Bladder Problem
□ Pacemaker	□ Seizures / Epilepsy	□ Previous Fracture
□ Vascular Disease	□ Metal in Body / Surgical Implants	□ Previous Surgeries
□ Stroke	□ Cancer / Tumor	□ Hearing Loss
□ Asthma	□ Recent Weight Loss / Gain	□ Depression
□ Shortness of Breath	□ Current Infection	□ Anxiety
□ Chronic Cough	□ Tuberculosis	□ Substance Abuse
□ Fainting Spells	□ Hepatitis	□ Other

If you checked off any of the above conditions, please describe and provide specific dates:

_____

_____

Do you have any allergies: _____

Please list any medications that you are currently taking: _____

_____

_____

How would you rate your health (Please circle one): Excellent Very Good Fair Poor

Patient Signature: _____ Date: ____/____/_____

PATIENT NAME:_____ **ID:**_____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

LEFS - INITIAL VISIT

Please rate your pain level with activity: NO PAIN= 0 1 2 3 4 5 6 7 8 9 10= VERY SEVERE PAIN

	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFZS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

Comorbidities:

- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____

ENEA Physical Therapy + Wellness
Acknowledgement of Policies

ENEA Physical Therapy + Wellness has the following office policies governing patient care. Please read each policy carefully and initial by each to signify your understanding and agreement to abide by these policies.

_____ ***Appointment Scheduling:*** We will strive to provide you with effective, efficient treatment and accommodate your needs to the best of our ability. To be fair to all patients, we ask for 24 Hours' notice for cancellations. If you are going to be late for your appointment, please call to let us know. Adherence to the recommended plan of care and consistency with appointment attendance is vital to your progress. Please make every effort to follow this plan. Lastly, if you miss more than 3 appointments without prior notification, we reserve the right to discontinue your therapy. *****We also reserve the right to apply a cancellation fee in the amount of $25.00 to your account for each cancellation without 24-hours' notice and for each "no show" appointment.**** Thank You.

_____ ***Consent for Treatment***: I voluntarily consent to physical therapy evaluation and treatment as prescribed by my attending physician or his/her designees as necessary under the direction of a registered physical therapist/physical therapist assistant. Further, I acknowledge that no guarantee has been made as to the results of such treatments.

_____ ***Privacy Practices Acknowledgement***: We take your privacy very seriously, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your patient rights. If you have questions about the use or dissemination of your personal health information, we would be happy to address them. By initialing this section, I, the undersigned acknowledge that a copy of ENEA Physical Therapy + Wellness's Notice of Privacy Practices for Protected Health Information has been made available to me.

_____ ***Assignment of Benefits:*** In consideration of agreement between ENEA Physical Therapy + Wellness and myself to provide me with physical therapy services, I hereby irrevocably assign to ENEA Physical Therapy + Wellness my right, title, and monetary interests in, and to all, insurance benefits which I may be entitled to. Assignment of such benefits is limited to the extent of the amount of cost of all services to me byENEA Physical Therapy + Wellness. I hereby authorize all payment for services provided by ENEA Physical Therapy + Wellness that may be due upon receipt of claims or itemized statements for services rendered.

_____ ***Billing/Information Release:*** I authorize ENEA Physical Therapy + Wellness to furnish all necessary parties any information it may have regarding my condition while under observation or treatment deemed necessary to facilitate reimbursement for services rendered. I acknowledge that ENEA Physical Therapy + Wellness is duly authorized such rights in accordance with all federal and state confidentiality laws.

_____ ***Responsibility of Payment***: I, the undersigned acknowledge full financial responsibility to ENEA Physical Therapy + Wellness for any and all charges not covered by my insurance policy. This includes Co-payments, deductibles, or charges that are denied by my insurance company.

I certify that I have read, understand and agree to abide by all office policies listed above.

Patient Signature: _____ Date: ___/___/_____

Name (Please Print) _____

Witness Signature: _____ Date: ___/___/_____

Name (Please Print): _____