

## ENE 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!**

**ENE Physical Therapy + Wellness**

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?		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Headaches
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hypersensitivity to Hot / Cold	<input type="checkbox"/> Head Injury / Concussion
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Swelling in Ankles	<input type="checkbox"/> Hernia
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Deep Vein Thrombosis (DVT)	<input type="checkbox"/> Kidney / Bladder Problem
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Seizures / Epilepsy	<input type="checkbox"/> Previous Fracture
<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Metal in Body / Surgical Implants	<input type="checkbox"/> Previous Surgeries
<input type="checkbox"/> Stroke	<input type="checkbox"/> Cancer / Tumor	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Asthma	<input type="checkbox"/> Recent Weight Loss / Gain	<input type="checkbox"/> Depression
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Current Infection	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

# Oswestry Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please check the box for the **one statement** in each section that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present-day situation. Thank you.

Patient name \_\_\_\_\_

Date \_\_\_\_\_

Please check one box in each section.

## Section 1 - Pain Intensity

- 0 I have no pain at the moment.
- 1 The pain is very mild at the moment.
- 2 The pain is moderate at the moment.
- 3 The pain is fairly severe at the moment.
- 4 The pain is very severe at the moment.
- 5 The pain is the worst imaginable at the moment.

## Section 2 - Personal Care (washing, dressing, etc.)

- 0 I can look after myself normally without causing extra pain.
- 1 I can look after myself normally, but it causes extra pain.
- 2 It is painful to look after myself, I am slow and careful.
- 3 I need some help but manage most of my personal care.
- 4 [ nee] help every Jay in most aspects of self-care.
- 5 I do not get dressed; I wash with difficulty and stay in bed.

## Section 3 - Lifting

- 0 I can lift heavy weights without extra pain.
- 1 I can lift heavy weights, but it gives me extra pain.
- 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned - for example on a table.
- 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 4 I can lift only very light weights.
- 5 I cannot lift or carry anything at all.

## Section 4 - Reading

- 0 I can read as much as I want to with no pain in my neck.
- 1 I can read as much as I want to with slight pain in my neck.
- 2 I can read as much as I want with moderate neck pain.
- 3 I can't read as much as I want because of moderate neck pain.
- 4 I can hardly read at all because of severe pain in my neck.
- 5 I cannot read at all.

## Section 5 - Headaches

- 0 I have no headaches at all.
- 1 I have slight headaches that come infrequently.
- 2 I have moderate headaches that come infrequently.
- 3 I have moderate headaches that come frequently.
- 4 I have severe headaches that come frequently.
- 5 I have headaches almost all the time.

Score: \_\_ (50)

Benchmark -5 = \_\_

## Section 6 - Concentration

- 0 I can concentrate fully when I want to with no difficulty.
- 1 I can concentrate fully when I want to with slight difficulty.
- 2 I have a fair degree of difficulty in concentrating when I want to.
- 3 I have a lot of difficulty in concentrating when I want to.
- 4 I have a great deal of difficulty in concentrating when I want to.
- 5 I cannot concentrate at all.

## Section 7 - Work

- 0 I can do as much work as I want to.
- 1 I can only do my usual work, but no more.
- 2 I can do most of my usual work, but no more.
- 3 I cannot do my usual work.
- 4 I can hardly do any work at all.
- 5 I can't do any work at all.

## Section 8 - Driving

- 0 I can drive my car without any neck pain.
- 1 I can drive my car as long as I want with slight pain in my neck.
- 2 I can drive my car as long as I want with moderate pain in my neck.
- 3 I can't drive my car as long as I want because of moderate pain in my neck.
- 4 I can hardly drive at all because of severe pain in my neck.
- 5 I can't drive my car at all.

## Section 9 - Sleeping

- 0 I have no trouble sleeping.
- 1 My sleep is slightly disturbed (less than 1 hour sleepless).
- 2 My sleep is mildly disturbed (1-2 hours sleepless).
- 3 My sleep is moderately disturbed (2-3 hours sleepless).
- 4 My sleep is greatly disturbed (3-5 hours sleepless).
- 5 My sleep is completely disturbed (5-7 hours sleepless).

## Section 10 - Recreation

- 0 I am able to engage in all my recreation activities with no neck pain at all.
- 1 I am able to engage in all my recreation activities, with some pain in my neck.
- 2 I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- 3 I am able to engage in a few of my recreation activities because of pain in my neck.
- 4 I can hardly do any recreation activities because of pain in my neck.
- 5 I can't do any recreation activities at all.

**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 by ENEA 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): \_\_\_\_\_