

Patient Information (Workman's Comp)

First Name: _____ MI: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Birthdate: ___/___/___ Day Phone: _____ Evening Phone: _____ Cell Phone: _____
Gender (circle): M / F Social Security #: _____ (Use signing parent's # if patient is minor under 19 yrs)
Email Address: _____ Can we email appointment reminders & information? Yes / No
Emergency Contact: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Workman's Comp Carrier Insurance Information

Have you attended Physical Therapy for this problem at another facility? Yes / No

If so, please tell us start date: ___/___/___ and end date: ___/___/___.

Insurance Company Name: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone#: _____
Date of Injury: ___/___/___ Carrier Case#: _____ WCB Case#: _____
Case Manager: _____ Phone#: _____ Fax#: _____
Are you currently working? Yes/No Your Employer at the time of the accident: _____
Employer Address: _____

Secondary Insurance Information: (private insurance if claim is denied)

Insurance Company Name: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone#: _____
ID#: _____ Group#: _____ Name of Insured Person: _____
Relation: _____ SS#: _____ Insured Employer: _____
Employer Address: _____

I give my permission to SportsFocus Physical Therapy, PC to Release information to my insurance company. I authorize payment directly to SportsFocus Physical Therapy, PC for treatment I receive.

Signature: _____ Date: ___/___/___
(Signature of Patient or Guardian if patient is under 19)

I agree I am primarily liable for all charges for services rendered by SportsFocus Physical Therapy, PC and agree to pay all amounts not paid by my insurance carrier(s) for any reason. If I am claiming coverage under Compensation laws, I understand I am fully liable if such coverage is subsequently denied. I agree to supply private insurance information in anticipation of such a denial. If I am claiming secondary coverage through an HMO (such as IHA, Com Blue or Univera), I understand I am responsible for obtaining a valid referral prior to treatment if required and that treatment without such a referral will cause me to be personally liable for today's charged as well as future charges.

Signature: _____ Date: ___/___/___
(Signature of Patient or Guardian if patient is under 19)

I have been advised of SportsFocus Physical Therapy's **Notice of Privacy Practices Regarding Patient Health Information**. You may request a copy of this at any time.

Signature: _____ Date: ____/____/____

(Signature of Patient or Guardian if patient is under 19)

Workman's Compensation

You must be covered by Workman's compensation insurance if you were injured at work or as a result of work-related activity. You are responsible for providing all necessary information such as carrier, carrier address and contact information, date of injury, case number, etc. We will bill worker's compensation as required by law however, occasionally, cases are sometimes decided by a worker's compensation judge to NOT fall under worker's compensation. In this event, you would become liable for our charges. If you have a secondary insurance on which you wish to rely, we must be given that information at the time of your **first** visit. HMO companies often require approvals and have benefits with limited visits. You should also be aware that if you fail to pursue a valid Worker's Compensation claim, your personal insurance will probably not cover physical therapy services and you will be personally responsible for the charges.

There are Medical Treatment Guidelines that guide treatment for injuries involving the low back, shoulder, knee and neck. This limits the length of treatment to 8 weeks for low back, neck and knee injuries and 12 weeks for shoulder injuries. If you are making adequate functional improvement in your rehabilitation and may benefit from additional physical therapy past these guideline recommendations, your **Physician** is required to send a variance form to the insurance carrier, Workman's Compensation Board and your attorney if you have one. We will facilitate the process by sending a progress note to the MD approximately 2 weeks before the end of the guideline limits. Once the MD's office faxes the request, the insurance carrier has 15 days to approve or deny the variance and notify the physician. If they do not respond within that time frame, you are able to continue with PT.

We will not be able to schedule appointments for you after the guideline limits without a variance approval and this may include the time while the variance is pending approval. In lieu of the fact that our office will not be informed of variance approval (only the MD's office is notified), please notify us of a variance approval as soon as possible so that you may continue with your physical therapy without any or at least minimal interruption of service.

Signature: _____ Date: ____/____/____

(Signature of Patient or Guardian if patient is under 19)

Cancellations are required 24 hours in advance. Cancellations and no-shows are recorded and shared with your insurance company and your physician. This may negatively affect your case.

For patients with an excessive number of cancellations and no shows, we reserve the right to limit them to same day scheduling. This would require a patient to call on the day they could attend PT and they would be limited to those times available for that day.

Signature: _____ Date: ____/____/____

(Signature of Patient or Guardian if patient is under 19)



Patient Intake Form

Name: _____ Age: _____ Height: _____ Weight: _____

Primary Physician: _____ Approximate date of last physical: ___/___/___

Which of the following factors contributed to you choosing SportsFocus? (Check all that apply)

- Doctor recommended
- Doctor's assistant recommended
- List provided by doctor
- Previous patient recommended
- Friend recommended
- I am a previous patient
- Location
- Web site or internet search
- Ad in the phone book

Who can we thank? _____

Referring Physician: _____ Date of follow-up visit: ___/___/___

What is your work status? (Check all that apply)

- Homemaker
- Not employed/Not seeking work
- On disability
- Retired
- Student
- Unable to work due to injury
- Unemployed seeking work
- Working
- Working, modified duty

Employer: _____ Occupation: _____

Please describe the physical requirements of your job. *For example: 30% of day sitting, 30% of day standing, 20% of day walking, 20% of day lifting boxes weighing between 10 and 20 pounds.*

What's the length of your typical work day? _____ hours Typical work week? _____ days

Did you have any limitation of function during normal daily activities before your present injury or onset of symptoms? Yes No

If Yes, please describe those limitations: _____

History of Current Complaints

Chief complaints: (Check all that apply)

- Balance problems
- Difficulty walking
- Difficulty with daily activities
- Dizziness
- Falls / history of falls
- Fatigue / poor endurance
- Headache
- Impaired sensation
- Joint stiffness
- Joint swelling
- Muscle tenderness
- Muscle weakness

Affected Side: Left Right Both

- Numbness
- Pain
- Problems breathing/shortness of breath
- Tingling
- Other 1 _____
- Other 2 _____

If there is pain, specify type of pain: (Check all that apply)

- Ankle pain
- Back pain
- Chest pain
- Elbow pain
- Foot pain
- Hand Pain
- Hip pain
- Jaw pain
- Knee pain
- Lower Extremity / Leg pain
- Neck pain
- Rib pain

- Shoulder pain
- Upper Extremity / Arm pain
- Wrist pain
- Other: _____

When did the current problem(s) begin? ___/___/___ Date of Injury: ___/___/___

If there is no specific date or you cannot recall, how long have you had these complaints? _____

Describe details of your injury or any activities that contributed to your current complaints: _____

How are you taking care of the current problem(s) now? _____

Are you seeing anyone else for the problem(s)? (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Nurse practitioner | <input type="checkbox"/> Primary care physician |
| <input type="checkbox"/> Athletic trainer | <input type="checkbox"/> Obstetrician/gynecologist | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Occupational therapist | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Osteopath | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Family practitioner | <input type="checkbox"/> Pediatrician | <input type="checkbox"/> Speech-Language Pathologist |
| <input type="checkbox"/> Internist | <input type="checkbox"/> Physiatrist (Physical Medicine and Rehabilitation) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Massage therapist | <input type="checkbox"/> Physical therapist | |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Podiatrist | |
| <input type="checkbox"/> Neurosurgeon | | |

Previous Episode

Has this problem occurred before? Yes No

If Yes, did the problem(s) get better? Yes No **Start Date:** ___/___/___ **End Date:** ___/___/___

About how long did the problem(s) last? _____ Day(s) Week(s) Month(s) Year(s)

Did you see anyone for the *previous episode*? (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Nurse practitioner | <input type="checkbox"/> Primary care physician |
| <input type="checkbox"/> Athletic trainer | <input type="checkbox"/> Obstetrician/gynecologist | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Occupational therapist | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Osteopath | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Family practitioner | <input type="checkbox"/> Pediatrician | <input type="checkbox"/> Speech-Language Pathologist |
| <input type="checkbox"/> Internist | <input type="checkbox"/> Physiatrist (Physical Medicine and Rehabilitation) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Massage therapist | <input type="checkbox"/> Physical therapist | |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Podiatrist | |
| <input type="checkbox"/> Neurosurgeon | | |

What else did you do for the previous problem(s)? _____

Hospitalization

Related/Recent Hospitalizations? Yes No *If Yes, date of Hospitalization* ___/___/___

Concerns/Interests

I am concerned about or have problems with: (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Bed mobility | <input type="checkbox"/> Performing sports, recreation, and play activities |
| <input type="checkbox"/> Climbing stairs | <input type="checkbox"/> Reaching over head |
| <input type="checkbox"/> Coordination | <input type="checkbox"/> Repetitive movements of the hand, arm, shoulder |
| <input type="checkbox"/> Difficulty with self care (such as bathing, dressing, toileting) | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Flexibility | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Grasping objects lifting | <input type="checkbox"/> Transfers (getting out of a chair, bed) |
| <input type="checkbox"/> Performing home management (household chores, shopping, care of dependents) | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Performing job responsibilities/community activities (work, school, volunteer) | <input type="checkbox"/> Writing/grasping items with hand(s) |
| | <input type="checkbox"/> Other: _____ |

I feel in need of or have interest in (Check all that apply):

Education Exercise Fitness Prevention Other: _____

Associated Surgeries / Injection or Epidural

Associated Surgery 1 Date: ___/___/___ **Associated Surgery 1:** _____

Associated Surgery 2 Date: ___/___/___ **Associated Surgery 2:** _____

Associated Surgery 3 Date: ___/___/___ **Associated Surgery 3:** _____

Injection Date: ___/___/___ **Epidural Date:** ___/___/___

Medical Screening

Do you currently, or have you ever had any of the following problems? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Foot pain/discoloration | <input type="checkbox"/> Prolonged fatigue |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Frequent heartburn or indigestion | <input type="checkbox"/> Pulsating pain in body |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Frequent or severe headaches | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Constant pain in body | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Stress/tension |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Hoarseness or changes in speech | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Unusual lumps or growths |
| <input type="checkbox"/> Difficulty or changes in swallowing | <input type="checkbox"/> Joint pain, swelling, or redness | <input type="checkbox"/> Unusual menstrual irregularities |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Loss of balance or falling | <input type="checkbox"/> Vision problems (i.e. blurred vision or loss of sight) |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Loss of pleasure in things usually enjoyed | <input type="checkbox"/> Weakness in arms or legs |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Numbness or changes in sensation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Feeling downhearted or blue | <input type="checkbox"/> Pain at night | |
| <input type="checkbox"/> Fever/chills/sweats | <input type="checkbox"/> Pain or cramping in lower leg (calf) | |

Comments for above: _____

Been Diagnosed

Have you been diagnosed with any of the following conditions? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head injury | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Heart Attack/MI | <input type="checkbox"/> Parkinson disease |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Circulation/vascular problems | <input type="checkbox"/> Hypercholesteremia | <input type="checkbox"/> Repeated infections |
| <input type="checkbox"/> COPD (chronic obstructive pulmonary disorder) | <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Deep vein thrombosis / PE | <input type="checkbox"/> Infectious disease (e.g., tuberculosis, hepatitis) | <input type="checkbox"/> Spinal cord injury |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Developmental or growth problems | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stomach problems/ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Vision impairment |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Other joint injuries _____ |
| <input type="checkbox"/> GERD (Gastro-Esophageal Reflux Disease) | <input type="checkbox"/> Obesity | <input type="checkbox"/> Other: _____ |

Comments for above: _____

Are you pregnant? Yes No Unsure *If Yes, what is your due date:* ___/___/___

Surgery

Have you ever had surgery? Yes No

Select which surgeries and enter the date: (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> ACL repair/reconstruction.....Date: ___/___/___ | <input type="checkbox"/> Hand surgeryDate: ___/___/___ |
| <input type="checkbox"/> Achilles tendon repairDate: ___/___/___ | <input type="checkbox"/> Heart transplantationDate: ___/___/___ |
| <input type="checkbox"/> AngioplastyDate: ___/___/___ | <input type="checkbox"/> Hernia repairDate: ___/___/___ |
| <input type="checkbox"/> Aortic valve surgeryDate: ___/___/___ | <input type="checkbox"/> HysterectomyDate: ___/___/___ |
| <input type="checkbox"/> AppendectomyDate: ___/___/___ | <input type="checkbox"/> Joint replacement: Which joint? _____ Date: ___/___/___ |
| <input type="checkbox"/> Arthroscopic surgery: Which joint: _____ Date: ___/___/___ | <input type="checkbox"/> Kidney transplantDate: ___/___/___ |
| <input type="checkbox"/> Arthroscopic examination: Which joint: _____ Date: ___/___/___ | <input type="checkbox"/> Lapband surgeryDate: ___/___/___ |
| <input type="checkbox"/> Back surgeryDate: ___/___/___ | <input type="checkbox"/> Liver transplantDate: ___/___/___ |
| <input type="checkbox"/> Bone marrow transplantDate: ___/___/___ | <input type="checkbox"/> LobectomyDate: ___/___/___ |
| <input type="checkbox"/> BunionectomyDate: ___/___/___ | <input type="checkbox"/> Lung surgeryDate: ___/___/___ |
| <input type="checkbox"/> Coronary artery bypass graftDate: ___/___/___ | <input type="checkbox"/> Lung transplantDate: ___/___/___ |
| <input type="checkbox"/> Caesarian sectionDate: ___/___/___ | <input type="checkbox"/> LumpectomyDate: ___/___/___ |
| <input type="checkbox"/> Cardiac catheterizationDate: ___/___/___ | <input type="checkbox"/> MastectomyDate: ___/___/___ |
| <input type="checkbox"/> Cardiac surgeriesDate: ___/___/___ | <input type="checkbox"/> Neck surgeryDate: ___/___/___ |
| <input type="checkbox"/> Carpal tunnel releaseDate: ___/___/___ | <input type="checkbox"/> Pacemaker/Defibrillator insertionDate: ___/___/___ |
| <input type="checkbox"/> Cholecystectomy (gallbladder removed)Date: ___/___/___ | <input type="checkbox"/> Plastic surgeryDate: ___/___/___ |
| <input type="checkbox"/> ChondroplastyDate: ___/___/___ | <input type="checkbox"/> Rotator cuff repairDate: ___/___/___ |
| <input type="checkbox"/> Colon surgeryDate: ___/___/___ | <input type="checkbox"/> SplenectomyDate: ___/___/___ |
| <input type="checkbox"/> ColostomyDate: ___/___/___ | <input type="checkbox"/> TracheostomyDate: ___/___/___ |
| <input type="checkbox"/> Femoral popliteal bypassDate: ___/___/___ | <input type="checkbox"/> Transurethral Resection of the ProstateDate: ___/___/___ |
| <input type="checkbox"/> Gall bladder surgeryDate: ___/___/___ | <input type="checkbox"/> Other: _____ Date: ___/___/___ |
| <input type="checkbox"/> Gastric Bypass surgeryDate: ___/___/___ | |

Medications

Please list all Prescription medications: (or provide list for photocopy) _____

Please list all Non-prescription medications: _____

Medical Tests

Within the last year, have you had any of the following tests? (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Angiogram | <input type="checkbox"/> EEG (electroencephalogram) | <input type="checkbox"/> Pap smear |
| <input type="checkbox"/> Blood tests | <input type="checkbox"/> EKG (electrocardiogram) | <input type="checkbox"/> Pulmonary function test |
| <input type="checkbox"/> Bone scan | <input type="checkbox"/> EMG (electromyogram) | <input type="checkbox"/> Spinal tap |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> Mammogram | <input type="checkbox"/> Urine tests |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> MRI | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> Doppler ultrasound | <input type="checkbox"/> Myelogram | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> NCV (nerve conduction velocity) | |

If Yes, describe test results _____

Allergies

List any allergies: _____

General Health Status

Please rate your general health: Excellent Very Good Good Fair Poor

Have you had any major life changes during past year?

(eg, new baby, job change, death of a family member): Yes No

Tobacco

Do you smoke? Yes No

Exercise

Do you exercise beyond normal daily activities and chores? Yes No

Physical activities: (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Golf | <input type="checkbox"/> Travel |
| <input type="checkbox"/> Biking | <input type="checkbox"/> Outdoor activities (hiking camping) | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Boating (rowing, sailing, canoeing) | <input type="checkbox"/> Running, jogging | <input type="checkbox"/> Weightlifting |
| <input type="checkbox"/> Bowling | <input type="checkbox"/> Skating | <input type="checkbox"/> Yoga, pilates, tai chi |
| <input type="checkbox"/> Cards, boardgames | <input type="checkbox"/> Swimming | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Gardening, yard work | <input type="checkbox"/> Team sports | |

On average, how many days per week do you exercise or do physical activity? _____

On average, how many minutes do you spend doing the exercise or physical activity for each session: _____

Weight Change

Have you experienced any recent weight change? No Increased Decreased # of pounds: _____

Timeframe of weight change: _____ Day(s) Week(s) Month(s) Year(s)