

Patient Medical History



Patient Name: _____

Referring Physician: _____

Patient Occupation _____

Emergency Contact Name: _____ Phone: (____) _____ - _____

Date of first MD visit for this problem or injury _____ Follow-up MD visit for this problem _____

Is this a work injury? Yes No Is an Attorney involved: Yes No

Date of Injury or onset of symptoms _____

How did your symptoms begin (gradually, suddenly, injury specifics)? _____

Have you had surgery for this problem/Injury: Yes No Type of Surgery _____

Date of Surgery _____

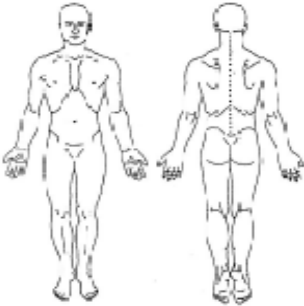
List your current medications. Include prescriptions, over-the-counter, herbs, and vitamins.

Medication	Dosage	frequency & route	Medication	Dosage	frequency & route
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are you allergic to any medications or latex? If yes please specify _____

Please list symptoms you are currently having (pain, swelling, weakness, etc) _____

Body Chart: Please mark the areas on the chart where you feel pain.



Please Circle your pain level:
0 being no pain & 10 Extreme pain
0 1 2 3 4 5 6 7 8 9 10

What is your main complaint? _____

Check all the activities that you have trouble performing as a result of your present condition.

- | | | | |
|-------------------------------------|-------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Child Care | <input type="checkbox"/> Dressing | <input type="checkbox"/> Eating |
| <input type="checkbox"/> Homemaking | <input type="checkbox"/> Yard work | <input type="checkbox"/> Sitting | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Working | |

How Long can you tolerate the following?

	Less than 30 min	1-2 hours	3-4 hours	No problems
Walking	_____	_____	_____	_____
Sitting	_____	_____	_____	_____
Standing	_____	_____	_____	_____

What treatment have you previously received for this injury/episode?

- | | | |
|---|---|--|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Chiropractic Care |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Medications: _____ | |
| <input type="checkbox"/> Other _____ | | |

Please circle if you have had any of these test done for this injury/episode: Bone Scan X-Ray MRI

CAT Scan EMG- NCV Myelogram Other _____

Do you have or have you had any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Muscular Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Parkinsons |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cardiac Conditions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Metal Implants | |

What are your expectations/goals during your Physical Therapy program? _____

Patient/Guardian Signature _____

Date _____

PATIENT NAME _____

Patient Date of Birth _____

Home Address _____

City _____ State _____ Zip Code _____

Phone Number (____) _____ - _____

Consent for Care and Treatment

I give my consent for treatment by the staff at PREMIER REHAB for physical therapy services and necessary treatment considered medically necessary as prescribed by my physician.

I understand that it is my responsibility to immediately communicate any difficulties and concerns that I have regarding my therapy to the staff at PREMIER REHAB.

Signature _____

Date _____

Benefit Assignment/Release of Information

I hereby authorize assignment of my insurance benefits to be paid directly to **PREMIER REHAB** for medical benefits to which I am entitled, including Medicare, private insurance, and third party payers for services performed during the course of my treatment at Premier Rehab.

I authorize Premier Rehab to release all information necessary including medical records to secure payment for Physical Therapy services provided by Premier Rehab staff.

PREMIER REHAB will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other healthcare operations. *Healthcare operations generally include those activities we perform to improve quality of care.*

Signature _____

Date _____

Appointment/Cancellation Policy

Premier Rehab requires that all appointments be cancelled and/or rescheduled within 24 hours of your scheduled appointment time. **If you cancel with less than 24 hours notice or fail to keep an appointment, you will be charged a \$25 no-show/late cancellation fee** which is due prior to your next scheduled appointment.

RELEASE OF INFORMATION

I hereby authorize Premier Rehab to release and disclose all Medical History to:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

I authorize Premier Rehab staff to leave any voice messages regarding appointments and or medical information when medically necessary to the following phone numbers (____) _____ - _____ and (____) _____ - _____

TEXT MESSAGING CONSENT: I consent to receiving text messages from Premier Rehab to wireless number (____) _____ - _____. *Text messages to the wireless number provided will include appointment reminders.*

EMAIL CONSENT: I consent to receiving email messages from Premier Rehab to the following email address _____@_____. *Email messages will include appointment reminders.*

I also understand that I have the right to terminate this authorization at any time in writing or verbally.

Patient Name (Printed) _____

Signature _____

Date _____

How did you hear about Premier Rehab? _____

Notification of Patient Responsibility for co-payments/Co-percentages and Deductibles

- We bill insurance carriers solely as a courtesy to the patient.
- Payment is due at each visit as determined by your benefits.
- The amount collected at each visit is only an estimate.
- Patient full responsibility will be determined once your claims are processed for payment by your insurance company.

Please list your health insurance plan(s):

Primary Insurance Name: _____ **ID Number:** _____

Insured Name: _____ **Insured DOB:** _____

Secondary Insurance Name: _____ **ID Number:** _____

Insured Name: _____ **Insured DOB:** _____

It is the patients' responsibility to inform our staff if there is a change in insurance coverage and or contact information to include address and contact phone numbers.

If a payment is made in the form of a check and the check is dishonored or returned for any reason there will be a processing fee of \$40.00 per check plus the original amount of each check.

Please read:

- If you have a secondary or tertiary insurance we will forward the claims for payment as a courtesy to you. This does not guarantee that you will not be financially responsible for any amounts left unpaid by either insurance plan.
- You the patient are responsible for payment of services rendered if your insurance denies payment due to exceeding your allowed visits and or dollar amount limit.
- You the patient are responsible for payment of services if you fail to respond to insurance requests for additional information that may lead to the denial of your claims.
- The patient is financially responsible for services rendered regardless of insurance coverage
- If any payment is made directly to the patient for services billed by PREMIER REHAB, the patient recognizes an obligation to promptly submit the same payment to PREMIER REHAB.

We highly recommend that you call your insurance to verify your Physical Therapy benefits.

By signing below you acknowledge having read this form in its entirety and fully understand your financial responsibilities as a patient.

Patient Name (Printed) _____

Signature of Patient or Legal Guardian _____

Date _____

PREMIER REHAB representative/witness _____ Date _____

PATIENT RIGHTS AND RESPONSIBILITIES

Patient rights and responsibilities were established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, family, physician, and facility caring for the patient. Patients shall have the following rights without regard to age, race, sex, national origin, religion, culture, physical handicap, personal values or belief systems.

THE PATIENT HAS THE RIGHT TO:

- Receive the care necessary to help regain or maintain his or her maximum state of health and, if necessary cope with death.
- Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience and perform the services for which they are responsible with the highest quality of service.
- Expect full recognition of individuality, including privacy in treatment and care. In addition, all communications and records will be kept confidential.
- Complete information, to the extent known by the physician, regarding diagnosis, treatment and prognosis, as well as alternative treatments or procedures and the possible risks and side effects associated with treatment.
- Be fully informed of the scope of services available at the facility, provisions for after hours and emergency care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's designated representative or other legally designated person shall exercise the patient's rights.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care or treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time.
- Change primary or specialty physicians or dentist if other qualified physicians or dentists are available.
- Have an advance directive, such as a living will or healthcare proxy. A patient who has an advance directive must provide a copy to the facility and his or her physician so that his or her wishes may be known and honored. Surgery centers and diagnostic imaging centers may be exceptions to this statement and will have a facility-specific policy.
- Be fully informed before any transfer to another facility or organization.
- Express those spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of medical therapy for the patient.

THE PATIENT IS RESPONSIBLE FOR:

- Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the facility.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her
- Keeping appointments and, when unable to do so for any reason, for notifying the facility and physician.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
- Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting the right to care at the facility and being responsible for the outcome.
- Promptly fulfilling his/her financial obligations to the facility.

Signature _____

Date _____

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Female	<input type="text"/>
Patient name Last	First	MI	<input type="radio"/> Male	Patient date of birth
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient address		City	State	Zip code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient insurance ID#	Health plan	Group number		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Referring physician (if applicable)	Date referral issued (if applicable)	Referral number (if applicable)		
<input type="text"/>	<input type="text"/>	<input type="text"/>		

Provider Information

<input type="text"/>		<input type="text"/>	
1. Name of the billing provider or facility (as it will appear on the claim form)		2. Federal tax ID(TIN) of entity in box #1	
<input type="text"/>		<input type="text"/>	
3. Name and credentials of the individual performing the service(s)		4. Alternate name (if any) of entity in box #1	
<input type="text"/>		<input type="text"/>	
5. NPI of entity in box #1		6. Phone number	
<input type="text"/>		<input type="text"/>	
7. Address of the billing provider or facility indicated in box #1		8. City	
<input type="text"/>		<input type="text"/>	
9. State		10. Zip code	
<input type="text"/>		<input type="text"/>	

Provider Completes This Section:

<p>Date you want THIS submission to begin:</p> <input type="text"/>	<p>Cause of Current Episode</p> <p>(1) Traumatic (4) Post-surgical (2) Unspecified (5) Work related (3) Repetitive (6) Motor vehicle</p>	<p>Date of Surgery</p> <input type="text"/>	<p>Diagnosis (ICD code) Please ensure all digits are entered accurately</p> <p>1° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>2° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>3° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>4° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>Patient Type</p> <p>(1) New to your office (2) Est'd, new injury (3) Est'd, new episode (4) Est'd, continuing care</p>	<p>Type of Surgery</p> <p>(1) ACL Reconstruction (2) Rotator Cuff/Labral Repair (3) Tendon Repair (4) Spinal Fusion (5) Joint Replacement (6) Other _____</p>	<p>DC ONLY</p> <p>Anticipated CMT Level</p> <p>(1) 98940 (2) 98942 (3) 98941 (4) 98943</p>	
<p>Nature of Condition</p> <p>(1) Initial onset (within last 3 months) (2) Recurrent (multiple episodes of < 3 months) (3) Chronic (continuous duration > 3 months)</p>		<p>Current Functional Measure Score</p> <p>Neck Index <input type="text"/> DASH <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Back Index <input type="text"/> LEFS <input type="text"/> (other) <input type="text"/></p>	

Patient Completes This Section:

<p>Symptoms began on: <input type="text"/></p> <p>(Please fill in selections completely)</p> <p>1. Briefly describe your symptoms:</p> <hr/> <p>2. How did your symptoms start?</p> <hr/> <p>3. Average pain intensity:</p> <p>Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain</p> <p>Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain</p> <p>4. How often do you experience your symptoms?</p> <p>(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)</p> <p>5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)</p> <p>(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely</p> <p>6. How is your condition changing, since care began at this facility?</p> <p>(0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better</p> <p>7. In general, would you say your overall health right now is...</p> <p>(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor</p>	<p>Indicate where you have pain or other symptoms:</p>
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Patient Signature: X _____ **Date:** _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- 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.

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).

Reading

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

Concentration

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

Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only 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 cannot do any work at all.

Personal Care

- 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 and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

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

Driving

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

Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

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

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck
Index
Score