FYZICAL®
Therapy & Balance Centers

PATIENT REGISTRATION

Name _____ Date _____
Last First MI

Address _____
Street City State Zip Code

Phone **w/area code** _____ Work Phone _____ Cell Phone _____

Social Security Number _____ Birth date _____ E-mail Address _____

Sex: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer _____ Occupation _____

Employer's Address _____ Your Primary Care Physician _____

Referring Physician _____ Date of your next visit _____

Name of person who should receive statement (other than patient) _____

Statement address (if different than patient's address) _____

Who should we contact in an emergency? _____ Phone number _____

INSURANCE INFORMATION – PLEASE GIVE YOUR CARDS TO RECEPTIONIST FOR COPYING

Primary Insurance _____

Insured's Name _____ Birth date _____

ID Number _____ Group Number _____

Secondary Insurance _____

Insured's Name _____ Birth date _____

ID Number _____ Group Number _____

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of accident _____ How did it happen? ☐ Auto ☐ Work ☐ Other (location) _____

Involvement in Accident if Auto ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Cyclist

Attorney's Name/Address/Phone _____

Insurance Company (worker's comp or your auto PIP) _____

Address _____ Phone number _____

Claim Number _____ Adjuster _____ Name of insured _____

Please tell us how you learned of our service or whom we can thank.

☐ I was a **Former Patient**
☐ **Former Patient** recommendation
Name _____

☐ **Doctor** recommendation
☐ **Family or Friend** recommendation
Name _____

☐ **Insurance Company** recommendation
☐ **Employer** recommendation
☐ **Case Manager** recommendation

☐ **Health Club** recommendation
☐ **Newspaper** advertisement
☐ **Yellow Page** advertisement

☐ **Clinic Sign**
☐ **Billboard** advertisement
☐ **Web page**

☐ **TV** advertisement
☐ **Radio** advertisement

I learned about you another way. Please explain. _____

FYZICAL®
Therapy & Balance Centers

PATIENT QUESTIONNAIRE / HEALTH HISTORY

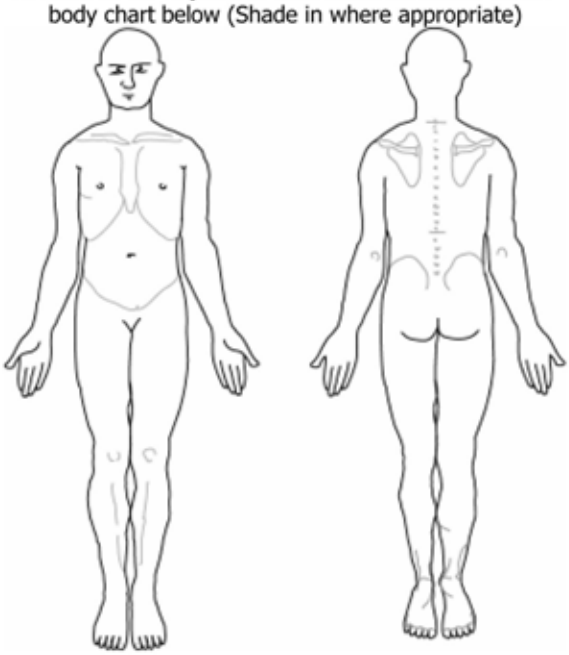
NAME: _____ **DATE:** _____

To insure you receive a complete and thorough evaluation. please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

HISTORY OF PRESENT CONDITION

1. What are your symptoms? _____

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade in where appropriate)



2. When did your symptoms begin?
(Please indicate a specific date if possible)_____

3. Was the **onset** of this episode gradual or sudden?(Check one)
❒ (1) gradual ❒ (2) sudden

4. Which of the following **best describes** how your injury occurred? (if your condition is post-surgical please indicate as per original injury)
- ❒ (1) lifting
- ❒ (2) a MVA (car accident
- ❒ (3) a fall
- ❒ (4) overuse (cumulative trauma)
- ❒ (5) trauma
- ❒ (6) degenerative process
- ❒ (7) during recreation/sports
- ❒ (8) running
- ❒ (9) a blow to the face
- ❒ (10) being hit by a ball
- ❒ (11) a dental appointment
- ❒ (12) throwing
- ❒ (13) an incident at work
- ❒ (14) unknown
- ❒ (15) other _____

5. Since onset, are your symptoms getting: (Check one)
❒ (1) better ❒ (2) worse ❒ (3) not changing

6. Have you had similar symptoms in the past? (1)❒ Yes (2) ❒ No
More than one episode? (1) ❒ Yes (2) ❒ No

7. Nature of pain/symptoms (check all that apply)
- ❒ (1) sharp
- ❒ (2) dull
- ❒ (3) throbbing
- ❒ (4) aching
- ❒ (5) periodic
- ❒ (6) occasional
- ❒ (7) constant
- ❒ (8) other _____

8. As the day progresses, do your symptoms: (Check one)
❒ (1) increase ❒ (2) decrease ❒ (3) stay the same

9. Does the pain wake you at night? ❒ (1) No ❒ (2) Yes
if "*yes*", is it present ❒ (1) while lying still
❒ (2) only when changing positions
❒ (3) both

10. Do you have pain/stiffness upon getting out of bed in the morning? ❒ (1) Yes ❒ (2) No

11. In what position do you sleep? (Check all that apply)
- ❒ (1) right side
- ❒ (2) left side
- ❒ (3) stomach
- ❒ (4) back
- ❒ (5) chair/recliner
- ❒ (6) back, sides, stomach
- ❒ (7) other _____

12. Since the onset of your current symptoms have you had:
- ❒ (1) any difficulty with control of bowel or bladder function
- ❒ (2) fever/Chills
- ❒ (3) any numbness in the genital or anal area
- ❒ (4) numbness
- ❒ (5) any dizziness or fainting attacks
- ❒ (6) weakness
- ❒ (7) unexplained weight change
- ❒ (8) night pain/sweats
- ❒ (9) malaise (vague feeling of bodily discomfort)
- ❒ (10) problems with vision/hearing
- ❒ (11) none of the above

13. What aggravates your symptoms? (Check all that apply)
- ❒ (1) sitting
- ❒ (2) going to/rising from sitting
- ❒ (3) lying down
- ❒ (4) walking
- ❒ (5) up/down stairs
- ❒ (6) reaching overhead
- ❒ (6) reaching in front of body
- ❒ (6) reaching behind back
- ❒ (6) reaching across body
- ❒ (7) talking, chewing, yawning, all (*circle one*)
- ❒ (8) recreation/sports including _____
- ❒ (9) repetitive activities including _____
- ❒ (10) household activities including _____
- ❒ (11) standing
- ❒ (12) squatting
- ❒ (13) sleeping
- ❒ (14) coughing/sneezing
- ❒ (15) taking a deep breath
- ❒ (16) looking up overhead
- ❒ (17) swallowing
- ❒ (18) stress
- ❒ (19) sustained bending
- ❒ (20) other _____

14. What relieves your symptoms? (Check all that apply)
- ❒ (1) sitting
- ❒ (2) heat
- ❒ (3) cold
- ❒ (4) stretching
- ❒ (5) wearing a splint/orthosis
- ❒ (6) rest
- ❒ (7) standing
- ❒ (8) walking
- ❒ (9) exercise
- ❒ (10) lying down
- ❒ (11) massage
- ❒ (12) medication
- ❒ (13) nothing
- ❒ (14) other_____

15. Have you had any previous treatment for this condition? (Check all that apply)

- ❒ (1) none
- ❒ (2) medication (oral)
- ❒ (3) joint manipulation
- ❒ (4) exercise
- ❒ (5) massage therapy
- ❒ (6) traction
- ❒ (7) bracing/taping
- ❒ (8) injection into the spine
- ❒ (9) injection into the skin/muscles
- ❒ (10) physical therapy
- ❒ (11) hypnosis
- ❒ (12) biofeedback
- ❒ (13) TENS unit
- ❒ (14) acupuncture
- ❒ (15) bed rest
- ❒ (16) overnight hospitalization
- ❒ (17) casting
- ❒ (18) other_____

16. Have you had any of the following tests?

- ❒ (1) none
- ❒ (2) x-rays
- ❒ (3) CT Scan
- ❒ (4) MRI
- ❒ (5) Arthrogram
- ❒ (6) Stress X-ray Test (Telos)
- ❒ (7) Bone Scan
- ❒ (8) NCS
- ❒ (9) Fluoroscope
- ❒ (10) Vestibular
- ❒ (11) other_____

Test Results:_____

MEDICATION

Please list any prescription medications you are currently taking (*pain pills, injections and/or skin patches, etc.*):

_____

_____

Prescribing MD:_____Phone:_____

Are you currently taking any of the following over the counter medications?

- ❒ (1) aspirin
- ❒ (2) Tylenol
- ❒ (3) corticosteroids
- ❒ (4) antihistamines
- ❒ (5) vitamins/mineral supplements
- ❒ (6) Advil/Motrin/ Ibuprofen
- ❒ (7) other_____

PREVIOUS FUNCTIONAL LEVEL

❒ **Independent in all activities** (work, community, home, recreation)

Self-care

- ❒ Independent in all self-care activities (bathing, toileting, dressing, etc.)
- ❒ Difficulty performing self-care activities
- ❒ Need assistance with self-care activities
- ❒ Difficulty performing household chores

Social

- ❒ Need assistance with activities in community outside of home

Hobbies:_____

WORK HISTORY

Occupation_____

- ❒ (1) employed full time
- ❒ (2) employed part time
- ❒ (3) self employed
- ❒ (4) homemaker
- ❒ (5) student
- ❒ (6) retired
- ❒ (7) unemployed
- ❒ (8) other_____

Physical activities at work (check all that apply)

- ❒ (1) sitting
- ❒ (2) standing
- ❒ (3) phone use
- ❒ (4) repetitive lifting
- ❒ (5) heavy lifting
- ❒ (6) computer use
- ❒ (7) heavy equipment operation
- ❒ (8) driving
- ❒ (9) other_____

Are you currently receiving or seeking disability for this condition? ❒ (1) Yes ❒ (2) No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

❒ (1) Yes ❒ (2) No

LIVING SITUATION

- ❒ (1) live alone
- ❒ (2) live with family members/others
- ❒ (3) live with caregiver
- ❒ (4) home/apartment
- ❒ (5) retirement complex (SNF/ICF)
- ❒ (6) assisted living complex
- ❒ (7) other_____

Setting

- ❒ (1) stairs (railing)
- ❒ (2) stairs (no railing)
- ❒ (3) no stairs
- ❒ (4) ramp
- ❒ (5) elevator
- ❒ (6) uneven ground
- ❒ (7) other_____

GENERAL HEALTH

How would you rate your general health?

❒ Excellent ❒ Average ❒ Poor
❒ Good ❒ Fair

Do you exercise outside of normal daily activities?

❒ 5+ days/wk ❒ 1-2 days/wk ❒ zero
❒ 3-4 days/wk ❒ occasionally

Exercise, Sports/Recreation consisting of _____

_____

Do you drink caffeinated beverages?

❒ No ❒ Yes How many/much per day_____

Do you smoke?

❒ No ❒ Yes Packs of cigarettes per day_____

What is your stress level?

❒ Low ❒ Medium ❒ High

Are you seeing any health care providers other than the physical therapist for this current condition? (Please list)_____

_____

_____

PAST MEDICAL HISTORY

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

- ❒ Cancer (type)_____
- ❒ Depression
- ❒ Stroke
- ❒ Kidney problems
- ❒ Thyroid problems
- ❒ Diabetes
- ❒ Multiple sclerosis
- ❒ Arthritis
- ❒ Head injury
- ❒ Stomach problems
- ❒ Parkinson's disease
- ❒ Infectious diseases (i.e. hepatitis, tuberculosis, etc.)
- ❒ Heart problems
- ❒ High blood pressure
- ❒ Lung problems
- ❒ Blood disorders
- ❒ Epilepsy/seizures
- ❒ Allergies
- ❒ Rheumatoid arthritis
- ❒ Osteoporosis
- ❒ Broken bone
- ❒ Circulation/vascular problems
- ❒ Other_____

Please list any recent/relevant past surgeries related to your current problem:

SURGERY	DATE

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated of any of the following?

- ❒ Diabetes
- ❒ Heart disease
- ❒ High blood pressure
- ❒ Stroke
- ❒ Other_____
- ❒ Cancer
- ❒ Arthritis
- ❒ Osteoporosis
- ❒ Psychological condition

FYZICAL® Therapy & Balance Centers

PATIENT WORKSHEET

NAME _____

DATE _____ ❒ Initial Visit ❒ Discharge Visit

PROBLEM AREA *(Please check one):*

❒ Upper Extremity (A,D) ❒ Lower Extremity (B,F) ❒ Cervical/Thoracic (C,D) ❒ Lumbar (D,F) ❒ TMJ (C,E)

FUNCTIONAL INDEX

PART I: *Answer all five sections in Part 1. Choose the one answer in each section that best describes your condition.*

WALKING

❒ Symptoms do not prevent me walking any distance.
❒ Symptoms prevent me walking more than 1 mile.
❒ Symptoms prevent me walking more than 1/2 mile.
❒ Symptoms prevent me walking more than 1/4 mile.
❒ I can only walk using a stick or crutches.
❒ I am in bed most of the time and have to crawl to the toilet.

WORK

(Applies to work in home and outside)

❒ I can do as much work as I want to.
❒ I can only do my usual work, but no more.
❒ I can do most of my usual work, but no more.
❒ I cannot do my usual work.
❒ I can hardly do any work at all (only light duty).
❒ I cannot do any work at all.

PERSONAL CARE

(Washing, Dressing, etc.)

❒ I can manage all personal care without symptoms.
❒ I can manage all personal care with some increased symptoms.
❒ Personal care requires slow, concise movements due to increased symptoms.
❒ I need help to manage some personal care.
❒ I need help to manage all personal care.
❒ I cannot manage any personal care.

SLEEPING

❒ I have no trouble sleeping.
❒ My sleep is mildly disturbed (less than 1 hr. sleepless).
❒ My sleep is mildly disturbed (1-2 hrs. sleepless).
❒ My sleep is moderately disturbed (2-3 hrs. sleepless).
❒ My sleep is greatly disturbed (3-5 hrs. sleepless).
❒ My sleep is completely disturbed (5-7 hrs. sleepless).

RECREATION/SPORTS

(Indicate Sport if Appropriate _____)

❒ I am able to engage in all my recreational/sports activities without increased symptoms.
❒ I am able to engage in all my recreational/sports activities with some increased symptoms.
❒ I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
❒ I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
❒ I can hardly do any recreational/sports activities because of increased symptoms.
❒ I cannot do any recreational/sports activities at all.

ACUITY

(Answer on initial visit.)

How many days ago did onset/injury occur?

_____ days

PART II: *Choose the one answer that best describes your condition in the sections designated by your therapist.*

■ A. UPPER EXTREMITY

CARRYING

❒ I can carry heavy loads without increased symptoms.
❒ I can carry heavy loads with some increased symptoms.
❒ I cannot carry heavy loads overhead, but I can manage if they are positioned close to my trunk.
❒ I cannot carry heavy loads, but I can manage light to medium loads if they are positioned close to my trunk.
❒ I can carry very light weights with some increased symptoms.
❒ I cannot lift or carry anything at all.

DRESSING

❒ I can put on a shirt or blouse without symptoms.
❒ I can put on a shirt or blouse with some increased symptoms.
❒ It is painful to put on a shirt or blouse and I am slow and careful.
❒ I need some help but I manage most of my shirt or blouse dressing.
❒ I need help in most aspects of putting on my shirt or blouse.
❒ I cannot put on a shirt or blouse at all.

REACHING

❒ I can reach to a high shelf to place an empty cup without increased symptoms.
❒ I can reach to a high shelf to place an empty cup with some increased symptoms.
❒ I can reach to a high shelf to place an empty cup with a moderate increase in symptoms.
❒ I cannot reach to a high shelf to place an empty cup, but I can reach up to a lower shelf without increased symptoms.
❒ I cannot reach up to a lower shelf without increased symptoms, but I can reach counter height to place an empty cup.
❒ I cannot reach my hand above waist level without increased symptoms.

■ B. LOWER EXTREMITY

STAIRS

❒ I can walk stairs comfortably without a rail.
❒ I can walk stairs comfortably, but with a crutch, cane, or rail.
❒ I can walk more than 1 flight of stairs, but with increased symptoms.
❒ I can walk less than 1 flight of stairs.
❒ I can manage only a single step or curb.
❒ I am unable to manage even a step or curb.

UNEVEN GROUND

❒ I can walk normally on uneven ground without loss of balance or using a cane or crutches.
❒ I can walk on uneven ground, but with loss of balance or with the use of a cane or crutches.
❒ I have to walk very carefully on uneven ground without using a cane or crutches.
❒ I have to walk very carefully on uneven ground even when using a cane or crutches.
❒ I have to walk very carefully on uneven ground and require physical assistance to manage it.
❒ I am unable to walk on uneven ground.

C. CERVICAL/TMJ

CONCENTRATION

- ❒ I can concentrate fully when I want to with no difficulty
- ❒ I can concentrate fully when I want to with slight difficulty.
- ❒ I have a fair degree of difficulty in concentrating when I want to.
- ❒ I have a lot of difficulty in concentrating when I want to.
- ❒ I have a great deal of difficulty in concentrating when I want to.
- ❒ I cannot concentrate at all.

HEADACHES

- ❒ I have no headaches at all.
- ❒ I have slight headaches which come less than 3 per week.
- ❒ I have moderate headaches which come infrequently.
- ❒ I have moderate headaches which come 4 or more per week.
- ❒ I have severe headaches which come frequently.
- ❒ I have headaches almost all of the time.

READING

- ❒ I can read as much as I want without increased symptoms.
- ❒ I can read as much as I want with slight symptoms.
- ❒ I can read as much as I want with moderate symptoms.
- ❒ I cannot read as much as I want because of moderate symptoms.
- ❒ I can hardly read at all because of severe symptoms.
- ❒ I cannot read at all.

D. LUMBAR*/CERVICAL/UPPER EXTREMITY

DRIVING

- ❒ I can drive my car or travel without any extra symptoms.
- ❒ I can drive my car or travel as long as I want with slight symptoms.
- ❒ I can drive my car or travel as long as I want with moderate symptoms.
- ❒ I cannot drive my car or travel as long as I want because of moderate symptoms.
- ❒ I can hardly drive at all or travel because of severe symptoms.
- ❒ I cannot drive my car or travel at all.

LIFTING

- ❒ I can lift heavy weights without extra symptoms.
- ❒ I can lift heavy weights but it gives extra symptoms.
- ❒ My symptoms prevent me from lifting heavy weights but I manage if they are conveniently positioned. (e.g. on a table)
- ❒ My symptoms prevent me from lifting heavy weights but I manage light to medium weights if they are conveniently positioned.
- ❒ I can lift only very light weights.
- ❒ I cannot lift or carry anything at all.

E. TMJ

TALKING

- ❒ I can talk without any increased symptoms.
- ❒ I can talk as long as I want with slight symptoms in my jaws.
- ❒ I can talk as long as I want with moderate symptoms in my jaws.
- ❒ I cannot talk as long as I want because of moderate symptoms in my jaws.
- ❒ I can hardly talk at all because of severe symptoms in my jaws.
- ❒ I cannot talk at all.

EATING

- ❒ I can eat whatever I want without symptoms.
- ❒ I can eat whatever I want but it gives extra symptoms
- ❒ Symptoms prevent me from eating regular food, but I can manage if I avoid hard foods.
- ❒ Symptoms prevent me from chewing anything other than soft foods.
- ❒ I can chew soft foods occasionally, but primarily adhere to a liquid diet.
- ❒ I cannot chew at all and maintain a liquid diet.

F. LUMBAR*/LOWER EXTREMITY

STANDING

- ❒ I can stand as long as I want without increased symptoms.
- ❒ I can stand as long as I want, but it gives me extra symptoms.
- ❒ Symptoms prevent me from standing for more than 1 hour.
- ❒ Symptoms prevent me from standing for more than 30 minutes.
- ❒ Symptoms prevent me from standing for more than 10 minutes.
- ❒ Symptoms prevent me from standing at all.

SQUATTING

- ❒ I can squat fully without the use of my arms for support.
- ❒ I can squat fully, but with symptoms or using my arms for support.
- ❒ I can squat 3/4 of my normal depth, but less than fully.
- ❒ I can squat 1/2 of my normal depth, but less than 3/4.
- ❒ I can squat 1/4 of my normal depth, but less than 1/2.
- ❒ I am unable to squat any distance due to symptoms .

SITTING

- ❒ I can sit in any chair as long as I like.
- ❒ I can only sit in my favorite chair as long as I like.
- ❒ My symptoms prevent me sitting more than 1 hour.
- ❒ My symptoms prevent me sitting more than 1/2 hour.
- ❒ My symptoms prevent me sitting more than 10 minutes.
- ❒ My symptoms prevent me from sitting at all.

** Lumbar questions adapted from Oswestry.*

PAIN INDEX

Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain — Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

IMPROVEMENT INDEX

Please indicate the amount of improvement you have made since the beginning of your physical therapy treatment on the scale below.

No Improvement — Complete Recovery

WORK STATUS *(check most appropriate)*

1. ❒ No lost work time
2. ❒ Return to work without restriction
3. ❒ Return to work with modification
4. ❒ Have not returned to work
5. ❒ Not employed outside the home

Work days lost due to condition: _____ days

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial: _____

PATIENT PRIVACY POLICY & PROCEDURE STATEMENT

Dear Patient:

GT Physical Therapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 662-773-3700.

GT Physical Therapy reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Thank you for choosing our health care facility.

Signature _____ **Date** _____

Patient/Guardian

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ **Date** _____
Patient / Guardian

I, the undersigned, do hereby agree and give my consent for GT Physical Therapy to furnish medical care and treatment to _____ which is considered necessary and proper in the diagnosing or treating of my (their) physical condition.

Signature _____ **Date** _____
Patient / Guardian

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION
FINANCIAL POLICY STATEMENT

I, the undersigned, hereby assign all medical benefits, ie.: Medicare, private insurance, major medical benefits, Worker's Compensation and any other health plans to which I am entitled to GT Physical Therapy. A photocopy of this assignment is to be considered as valid as the original.

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurance are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurance as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.

All co-insurance percentages paid at time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated amount and actual co-insurance due.

If any payments of medical benefits are made directly to you for services rendered by GT Physical Therapy, you must promptly remit such payment directly to GT Physical Therapy.

If you are a Worker's Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for charges if your Worker's Compensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature _____ **Date** _____
Patient / Guaradian