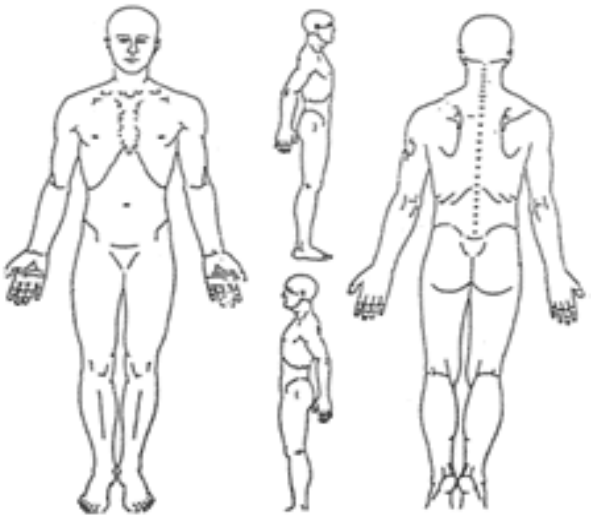
PHYSICAL THERAPY INNOVATIONS

PAIN SCALE

1. Please rate your pain with **0 as No Pain** and **10 as Unbearable** for:

   Pain at its WORST _____
   Pain at its BEST _____
   Pain CURRENTLY (TODAY) _____

Indicate where you have pain on the diagram



2. **How often do you experience your symptoms?**
   - Constantly (76-100% of the day)
   - Frequently (51-75% of the day)
   - Occasionally (26-50% of the day)
   - Intermittently (0-25% of the day)

3. **Type of Pain:**
   - Sharp
   - Shooting
   - Dull Ache
   - Numb
   - Burning
   - Tingling

4. **How are your symptoms changing?**
   - Getting Better
   - Not Changing
   - Getting Worse

5. **When did your symptoms begin?**
   _____
   _____

6. **How did your symptoms begin?**
   _____
   _____

7. **What tests have you had for your symptoms and when were they performed?**
   - **X-RAYS**: date taken: _____
   - **MRI**: date taken: _____
   - **CT SCAN**: date taken: _____
   - **OTHER:** date taken: _____

9. **Have you received Physical Therapy treatment this year?** YES NO

10. **If so how many visits:**_____

    For what diagnosis: _____

11. **Who have you seen for your current symptoms?**
    - No One
    - Chiropractor
    - Medical Doctor
    - Physical Therapist
    - Other

12. **What is your occupation?**
    _____

13. **What sports, exercise, or physical activities do you regularly participate in?**
    _____
    _____
    _____

Patient Name:_____

Date: _____

Medical History

Name:_____ Date:_____

1. Do you currently or have you ever had any of the following **Health Issues**? ***PLEASE CHECK ALL THAT APPLY***.

- ☐ Cancer (List Type or Location) _____
- ☐ Diabetes
- ☐ Heart Attack/Heart Disease
- ☐ Cardiac Pace Maker
- ☐ Stroke
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Infectious Disease (describe): _____
- ☐ Seizures/Epilepsy/Fainting
- ☐ Osteoporosis or Osteopenia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pregnancy (Current or Possible)
- ☐ Liver Disease
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Tobacco Use
- ☐ Stomach Issues / GERD
- ☐ Kidney Problems
- ☐ Bowel or Bladder Dysfunction
- ☐ Circulatory Problems or Blood Clots
- ☐ Bleeding Disorder/Blood Thinners
- ☐ Arthritis (Please list type or area) _____
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Cerebral Palsy
- ☐ Muscular Dystrophy
- ☐ Alcohol or Drug Abuse
- ☐ Alzheimer's or Dementia
- ☐ Depression or Anxiety
- ☐ Other (describe): _____ _____

2. Do you have any **Allergies**? Please Circle Yes or No If so please list:_____
How do you treat a reaction:_____

3. Please describe any and all **Surgical Procedures or Traumas** you have had that required medical treatment. Details such as dates of surgeries or hospitalizations are helpful to include:

_____
_____
_____
_____

3. Please list any and all **Medications** you take on a regular basis including over the counter meds or supplements:

_____
_____
_____
_____

4. Please list any **Physical Therapy, Occupational Therapy, Chiropractic or Massage Therapy** that you have received in the past with approximate dates and what conditions were or are currently treated:_____

_____
_____

5. Please describe how you spend your **Workday** (sitting at a desk, standing, driving, manual labor, climbing, etc.):

_____
How long is your commute to work (minutes): _____ How many hrs a day do you sit at a desk:_____
(*If you do not work, please describe your typical day's tasks or activities, i.e. household chores, child care, etc.)*

6. Please list any **Other** past or current health information we should know: _____

_____
_____

PHYSICAL THERAPY
INNOVATIONS

Patient Name: _____ Date: _____/_____/_____

Please indicate any medications you are currently taking, why you take those medications, any surgeries or medical issues (past or present), and any previous physical therapy you have had in the columns below:

Current Medications	Reason(s) for Medications	Surgeries/Medical Issues	Previous Physical Therapy

PHYSICAL THERAPY INNOVATIONS
489 Washington Street, Suite 200
Auburn, MA 01501
508.721.0000

PRACTICE AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION (PHI)

By signing, I authorize **Physical Therapy Innovations, Inc.** to obtain or release certain protected health information (PHI) about me from or to the following:

PTI to Obtain ☐ **PTI to Release** ☐

Name: Address: Phone #:

_____

_____

_____

If PTI is given authorization to release your PHI to the indicated name(s) above, please provide the relationship to the patient: (1) _____ (2) _____ (3) _____.

I request the following **restrictions** to be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

_____

_____

I have the right to revoke this authorization in writing, except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Physical Therapy Innovations, Inc.
489 Washington Street, Suite 200
Auburn, MA 01501
508.721.0000

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Print Patient's Name — Date

_____
Print Name of Legal Guardian, if applicable

Effective October, 2011

CONDITIONS AND CONSENT FOR PHYSICAL THERAPY

Informed Consent for Treatment: The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial evaluation concerning the treatment and options available for my condition.

Potential Benefits: These may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential Risks: I understand I may experience an increase in my current level of pain and discomfort, or an aggravation of my existing injury. This discomfort is usually temporary. If it does not subside within 24 hours, I agree to contact my physical therapist.

No Warranty: I understand that my physical therapist at Physical Therapy Innovations, Inc. cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me her/his opinions regarding potential results from physical therapy treatment for my condition and will discuss treatment options with me.

Alternatives: If I do not wish to participate in physical therapy, I will discuss my medical, surgical, or pharmacological alternatives with my physician.

I have read the above information and I consent to physical therapy evaluation and treatment. By signing below, I acknowledge that I have read, understood, and will abide by the conditions and policies noted on this consent form.

☐ (Check if Applicable) **Consent to treat a minor –** I the parent/guardian of _____ authorize PTI to treat the minor patient named above while I am not present.

_____	_____	_____
PRINTED PATIENT NAME	**PATIENT/PARENT/GUARDIAN SIGNATURE**	**DATE**

_____	_____
THERAPIST SIGNATURE	**DATE**

PHYSICAL THERAPY INNOVATIONS
Trusted for our reputation. Chosen for our care.

Physical Therapy Innovations

(hereinafter referred to as "PTI")

Patient's General and Emergency Contact Information Sheet

Please complete this form by affixing a check mark at each applicable section to indicate acceptable manner(s) in which PTI can contact you.

☐ In case of an emergency I authorize PTI to contact _____

at (_____) _____-_____. My relationship to contact is: _____.

I wish to be contacted by PTI in the following manner (please check each applicable section that indicates an acceptable manner(s) in which PTI can contact you):

☐ Please contact me on my home telephone: (_____) _____-_____.

- ☐ PTI can leave their name and phone number only when they call.
- ☐ PTI can leave a detailed message when they call.

☐ Please contact me by voice or text on my cellular phone: (_____) _____-_____.

- ☐ PTI can leave their name and phone number only when they call or text.
- ☐ PTI can leave a detailed message when they call or text.

☐ Please contact me at work: (_____) _____-_____

- ☐ PTI can leave their name and phone number only when they call.
- ☐ PTI can leave a detailed message when they call.

☐ PTI can mail, email or text me communications such as a welcome letter, appointment reminders, newsletter or other information about future PTI sponsored events or programs.

- ☐ PTI can mail information to my home address or PO Box.
- ☐ PTI can mail information to my work address or PO Box.
- ☐ PTI cannot mail information to my home, work address or PO Box except statements of my account.
- ☐ PTI can send email messages such as appointment reminders or other at the following email address: _____. (Leave blank if you do not wish to be contacted via email.)
- ☐ PTI can send text messages such as appointment reminders or other at the following cellular number: (_____) _____-_____.

_____	_____	_____
Patient's Name (Please Print)	Signature of Patient, Parent or Legal Guardian	Date

FINANCIAL AGREEMENT

1. I understand that health insurances, worker's compensation, motor vehicle/personal injury and other third party payer policies are arrangements by and between insurance carriers and the subscriber. Furthermore, I understand that it is my responsibility to be aware of the benefits available to me through my insurance carrier and that it is in my best interest to call my health insurance company to verify my individual benefits. I understand that I am responsible for acquiring a prescription for physical therapy from my primary care physician (PCP) and/or referring physician. I also understand that I am responsible for securing a referral, pre-authorization and/or claim number from my health insurance carrier, worker's compensation carrier, and or motor vehicle/personal injury third party payor. **If this information is not provided to Physical Therapy Innovations, Inc. (hereinafter PTI) at the time of my first visit, I agree that I am responsible to pay out-of-pocket for the services rendered to me until such time the information (referral, claim number, pre-authorization, and prescription) is provided to PTI.**
2. I authorize the release of any and all medically necessary information to process all claims related to services rendered at PTI, **including but not limited to all relevant insurance companies, 3rd party administrators, PCP's and referring physicians**.
3. I authorize payment of medical benefits directly to PTI for professional services rendered.
4. I understand that payment for all services rendered to me is ultimately my individual responsibility.
   a. Co-payment and payments toward deductibles/co-insurances are due and payable at time of service.
   b. Any and all unpaid balances for professional services are due within 30 days of discharge from services at PTI. If any payment is not received within 30 days, all balances are subject to an 18% finance charge annually.
5. **PTI requires a 24 hour cancellation notice. There is a $35.00 service fee for no-shows or cancellations without proper notice. This charge is not covered by your medical insurance and is billed directly to the patient and will be collected at the time of the next scheduled appointment. Repeated missed appointments may warrant discontinuance of care. _____(patient initials).**
6. Your appointment may be cancelled and you may be charged for the cost of your treatment session, if you are more than 10 minutes late for your appointment.
7. There is a $35.00 returned check fee.
8. **If there are any changes to your health insurance benefits or carrier, it is your responsibility to notify and update PTI within 10 business days.**
9. If your injury is related to a motor vehicle accident, personal injury or a worker's compensation injury, it is your responsibility to inform PTI.
10. It is your responsibility to inform PTI if you have secondary insurance.

☐ **(Check if applicable) Consent to Financial Responsibility of a Minor**

I the parent/guardian of _____ authorize PTI to bill my insurance for treatment of minor patient named above while I am not present for the treatment.

I have read and agree with the provisions within PTI's financial agreement. I further acknowledge that all the information given, whether oral or written by me to Physical Therapy Innovations, Inc. is true.

_____ _____ _____

Signature of Patient | Signature of Responsible Party | Date

_____ _____

Signature of Authorized Clinic Representative | Date