Greenwood Physical Therapy

Patient Medical History

Name: _____ **Referring Physician:**_____

Family Physician: _____ **First Doctor Visit for Injury:** _____

Last date worked due to injury:_____ **Date returned to work after injury:**_____

Is there an attorney involved in this case? _____ **Date of injury?** _____

Date of next Doctor visit:_____

Have you had surgery for this injury?_____ **Number of Surgeries:**_____ **Date(s):** _____

Type of Surgery: _____

Where did your surgery take place: _____

Current Level of Pain (0 being no pain, 10 being pain requiring Emergency Room Care)

(Circle only one) 1 2 3 4 5 6 7 8 9 10

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATION:_____

If yes, please list: _____

PLEASE CHECK ANY OF THE FOLLOWING MEDICAL OR REHABILITATIVE SERVICES YOU HAVE RECEIVED FOR THIS CONDITION

____Orthopedist	____ Physical Therapy	____ X-Rays	____ EMG
____Occupational Therapy	____ CT Scan	____ NCV	____ Neurologist
____ Massage Therapy	____ MRI	____ Injection	____ General Practitioner
____ Myelogram	____ Cast or Brace	____ Emergency Room Care	____ Chiropractor

____ Other_____

PLEASE CIRCLE ANY OF THE FOLLOWING ITEMS THAT PERTAIN TO YOUR HEALTH HISTORY

Asthma	Sleeping Problems	Allergies	Shortness of Breath
Emotional	Psychological	Anemia	Coronary Heart Disease
Headaches	Infectious Disease	Chest Pain	Numbness/Tingling
Neurological Problems	Pacemaker?	Dizziness or Fainting	Diabetes
High Blood Pressure	Blurred Vision	Metal Implants	Heart Attack
Ringing in the Ears	Cancer	Heart Surgery	Weakness
Do you Smoke?	Epilepsy or Seizures	Arthritis or Swollen Joints	Blood Clot or Emboli
Night Sweats/Pain	Are you Pregnant?	Hernia	Osteoporosis
Thyroid Trouble	Urinary Problems	Recent Fever Pain	Unrelieved by position
Varicose Veins	Stroke/TIA (Date) _____	Alcohol/Drug Dependence	(or rest)
Autism	Dementia	Other: _____	

ARE THERE ANY NEUROLOGICAL ISSUES THAT WILL IMPAIR COMMUNICATION? YES NO

PLEASE LIST ANY SURGERIES YOU HAVE HAD IN THE PAST: _____

_____

PLEASE LIST THREE GOALS YOU WOULD LIKE TO ACHIEVE WHILE IN THERAPY:

1. _____
2. _____
3. _____

EMERGENCY CONTACT: _____ **PHONE:** _____

PATIENT (OR GUARDIAN SIGNATURE): _____ **Date:** _____

Greenwood Physical Therapy

Patient Name: _____ DOB: _____

GENERAL CONSENT AND ACKNOWLEDGEMENT

CONSENT FOR DIAGNOSIS, CARE AND TREATMENT

I understand and acknowledge that this General Consent and Acknowledgement applies to care and treatment I receive at Greenwood Physical Therapy.

I consent to and authorize the physical therapists and other health care providers who may be involved in my care to provide such diagnosis, care and treatment considered necessary for the care I am seeking or as may otherwise be advisable for my well being. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at Greenwood Physical Therapy. I understand that health care providers in training, including students, may be involved in my care and treatment and I consent to their involvement in my care. I understand that if I leave the practice without the consent of the physician and/or fail to carry out instructions for follow-up care; I do so at my own responsibility. I further understand that any injury or harm I may suffer while away from Greenwood Physical Therapy will be my responsibility.

_____ Initial

USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that Greenwood Physical Therapy will use and disclose my health information for the purposes of treatment, payment, and healthcare operations. I understand, acknowledge and consent to the release of my personal health information for the purposes outlined in this section, as described in the Notice of Privacy Practices which has been offered to me, and as may otherwise be permitted by law.

_____ Initial

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Greenwood Physical Therapy's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I may request a copy of any amended Notice of Privacy Practices at each appointment. In accordance with the policy there will be no electronic devices allowed in the gym area. I understand the information Greenwood Physical Therapy acquires or creates about me will only be disclosed to others for treatment, payment and health care operations as set forth in the notice or as authorized by me in writing.

_____ Initial

268 Greenwood Ave
Suite 202
Bethel, CT 06801
Phone 203-917-4792 * Fax 203-917-4798

Patient Name: _____ DOB: _____

CANCELLATION AND NO SHOW POLICY

Your physician has recommended physical therapy to remedy the condition that is affecting you; therefore it is absolutely necessary that you attend all of your scheduled appointments. Your therapist will advise you at your evaluation how many times a week it will be necessary for you to attend. ALL appointments missed MUST be made up in the same week so you may fully recover. Greenwood Physical Therapy requires 24 hours notice for any cancellation. If you do not give 24 hour advance notice for any cancellation or you do not show for your scheduled appointment an administrative fee of $50 will be billed to you.

_____ Initial

ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT

I guarantee payment of all charges incurred for services rendered by Greenwood Physical Therapy for the patient name on the top of the page. I guarantee the amount due for non insurable charges including, but not limited to, co-payment, deductibles, denied claims etc. If private health insurance, Medicare, Medicaid, other governmental or other insurance programs cover my treatment, I authorize Greenwood Physical Therapy to bill any such insurer for all charges incurred by me in connection with my diagnosis, care and treatment. I, as the responsible party, agree to furnish Greenwood Physical Therapy with up-to-date insurance. Any changes in insurance coverage must be reported to the office immediately. If my insurance plan requires a referral for me to come to Greenwood Physical Therapy, I understand that I am responsible for securing that referral. I further acknowledge that failure to do so may mean that I will not be seen upon arrival at the office. Acceptable methods of payment are cash or check. All refunds will be issued back to original form of payment.

Treatment from a **chiropractor** and physical therapy are billed using the same codes therefore they cannot be billed on the same day. One appointment will be approved and the other denied. Please be sure to make the staff aware if you are being treated by a chiropractor concurrently so the front desk can adjust your physical therapy schedule as necessary.

_____ Initial

_____ _____

Signature of Patient or Responsible Party if Minor Date *Date*

_____

Please print name of patient

268 Greenwood Ave
Suite 202
Bethel, CT 06801
Phone 203-917-4792 * Fax 203-917-4798

Back Index

ACN Group, Inc. Form BI-100

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

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back 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 The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

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

Back Index Score _____