Registration and Medical Profile Questionnaire

Please fill out the following questionnaire as completely as possible. This enables your therapist to design a safe and appropriate treatment plan for you. **Your input is very important.**

Last Name: ____________________ First: ____________________ Middle: __________

How did you hear about us? ☐ Physician ☐ Family/Friend ☐ Internet ☐ Phone Book ☐ Other: __________________

The kindest compliment you can give to us if the referral of a friend or family member. We reward our client based referrals with a certificate good towards cash services, such as massage or performance and golf analyses. If you were referred by a friend or family member, please let us know their name so we may thank them.

Name: ____

CONTACT INFORMATION:

Mailing Address: ____

City: ______________________ State: ______________ Zip: ____________

Home: ______________ Work: ______________ Cell: ______________

Email: ______________________________ SSN: ________-_______-________

EMERGENCY CONTACT: (Someone not living at the same address)

Name: ______________________________ Relation: ______________

Address: ____

Phone: ______________________ Other: ______________________

PERSONAL INFORMATION:

Sex: ☐ Male ☐ Female DOB: _______/_______/_______

Referring Provider: ______________________________ Last Seen: _______/_______/_______

Primary Care Provider: ____

Diagnosis: ____

Employer: ____

Job Title: ____

Was This an Injury? ☐ Yes ☐ No Is this work related? ☐ Yes ☐ No Is this related to a Car Accident? ☐ Yes ☐ No

Date of Injury: _______/_______/_______ Claim Number: ______________________________

Claims Manager: ____

Phone: ________________Ext: ________ Fax: ________________ Claim open/allowed? ☐ Yes ☐ No

Name: ____ DOB: ______________________

BILLING/INSURANCE INFORMATION: **Primary Insurance**

PRIMARY Insurance Provider: ____

ID/Member #: ____ Group #: ____________________________

Claims Address: ____

Phone: ____ Fax: ____

Subscriber Name: ____

Subscriber DOB: _______/_______/_______ Relation to Patient: ____

Please call your insurance provider(s) before your appointment. The phone numbers are usually located on the back of the card. We ask that *you* find out as much information as possible. The questions below should be asked and will help you to understand your OUT PATIENT PHYSICAL THERAPY benefits and be aware of any limitations, exclusions and/or out of pocket expenses your insurance provider may require.

Please note: **This is a QUOTE OF BENEFITS and NOT A GUARANTEE OF PAYMENT.**

Name of representative: ___________________________________ Date: ____/____/____Effective date: ____/____/____

Benefits: Dollar Limit/Year $__________________ Visit Max/Year: ___________________ Paid at: ______________%

Co-Pay: $____________ Any Physical Therapy used this year? ☐ Yes ☐ No Amount? _________________________

Deductible? $___________________________ Met? ☐ Yes ☐ No Balance: $___________________________

Out Of Pocket Max? $_________________________ Met? ☐ Yes ☐ No Balance: $________________________

Requirements Needed for Payment: ☐ Referral ☐ Prescription: PCP or Specialist ☐ Pre-Authorization

Pre-Authorization Number: _____________________ Number of Visits: ___________ Dates: ___/___/___ - ___/___/___

Is my Physical Therapist rendering therapy in network or out of network? ☐ In Network ☐ Out of Network

****For Car Accident or Work Related Injuries only. **** Claim open and allowed? ☐ Yes ☐ No

☐I have personally chosen **not to verify** my outpatient physical therapy benefits. I understand that if services are provided that are not covered by my insurance company, I am responsible to pay for those charges in full.

☐I have personally verified my Physical Therapy benefits. I have asked any questions, and I feel I have had all of my questions answered regarding these issues. I understand that the information I was provided was a quote of benefits and not a guarantee of payment. Payment determinations are based on the date services are rendered and when the claim is received. I now feel that I am fully informed of my benefits and am ready to proceed with treatment.

Signature: ____ Date: _________________________

Name: ____ DOB: _____________________

BILLING/INSURANCE INFORMATION: **Secondary Insurance** (if applicable)

SECONDARY Insurance Provider: ____

ID/Member #: ____ Group #: ___________________________

Claims Address: ____

Phone: ____ Fax: ____

Subscriber Name: ____

Subscriber DOB: _______/_______/_______ Relation to Patient: ____

Please call your insurance provider(s) before your appointment. The phone numbers are usually located on the back of your card. We ask that *you* find out as much information as possible. The questions below should be asked and will help you to understand your OUT PATIENT PHYSICAL THERAPY benefits and be aware of any limitation, exclusions and/or out of pocket expenses your insurance provider may require.

Please note: **This is a QUOTE OF BENEFITS and NOT A GUARANTEE OF PAYMENT.**

Name of representative: __________________________________ Date: ____/____/____Effective date: ____/____/____

Benefits: Dollar Limit/Year $_________________ Visit Max/Year: __________________ Paid at: ______________%

Co-Pay: $____________ Any Physical Therapy used this year? ☐ Yes ☐ No Amount? ________________________

Deductible? $_________________________ Met? ☐ Yes ☐ No Balance: $___________________________

Out Of Pocket Max? $________________________ Met? ☐ Yes ☐ No Balance: $________________________

Requirements Needed for Payment: ☐ Referral ☐ Prescription: PCP or Specialist ☐ Pre-Authorization

Pre-Authorization Number: ____________________ Number of Visits: ___________ Dates: ___/___/___ - ___/___/___

Is my Physical Therapist rendering therapy in network or out of network? ☐ In Network ☐ Out of Network

****For Car Accident or Work Related Injuries only. **** Claim open and allowed? ☐ Yes ☐ No

☐I have personally chosen **not to verify** my outpatient physical therapy benefits. I understand that if services are provided that are not covered by my insurance company, I am responsible to pay for those charges in full.

☐I have personally verified all of my Physical Therapy benefits. I have asked any questions, and I feel I have had all of my questions answered regarding these issues. I understand that the information I was provided was a quote of benefits and not a guarantee of payment. Payment determinations are based on the date services are rendered and when the claim is received. I now feel that I am fully informed of my benefits and am ready to proceed with treatment.

Signature: ____ Date: _________________________

Name: ____ DOB: ____________________

CASE HISTORY: **Problem #1** (if more than one problem, please complete separate forms for each)

Date of Onset: _______/_______/_______ Onset due to: ____

CURRENT COMPLAINTS:
☐ Stiffness/Tightness ☐ Tingling ☐ Weakness ☐ Difficulty Walking ☐ Imbalance ☐ Numbness ☐ Severe Pain

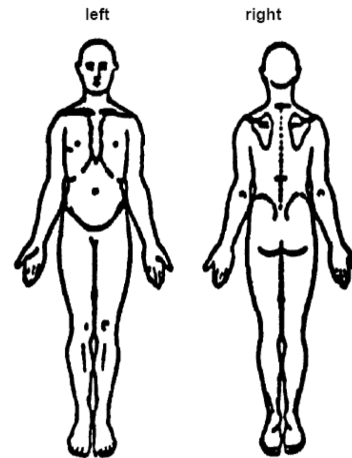
☐ Moderate/Mild Pain ☐ Loss of Function ☐ Other: ______________________________

PAIN:
Pain Frequency: ☐ Constant Steady ☐ Constant Variable ☐ Comes and Goes ☐ Occasional ☐ Sporadic ☐ Rare

Pain Quality: (check all that apply) ☐ Aching ☐ Burning ☐ Dull ☐ Pulsing ☐ Stabbing ☐ Steady ☐ Throbbing

Please describe your AREA or BODY PART of pain or complaint____.
(please fill in or circle the area on the bodies below as well)

Pain Rating:
Rate your pain on a scale from 0-10 (0= NO PAIN and 10= WORST PAIN you can imagine)



Your pain today..___________.

The BEST it has been since the onset.............................___________.

The WORST it has been since the onset..........................___________.

Recent symptom status: ☐ Improving ☐ Unchanged ☐ Worsening

Functional Levels: Prior to onset: _________% Present: ________%

Last time was 100%: ____.

Pain Behavior:
Does time of day affect your symptoms? ☐ Yes ☐ No If yes, describe how. ______________________________

What activities make you BETTER? ____

What activities make you WORSE? ____

What activities are you CURRENTLY UNABLE to do because of your symptoms? ______________________________

Current Treatment for this condition include: ____

Effects of Current Treatment: ____

Diagnostic Testing: ☐ None ☐ X-ray ☐ MRI ☐ Bone Scan ☐ CT Scan ☐ EMG ☐ NCV ☐ Other _______________
*Please bring any and all reports and/or results of any testing or scans related to the current condition.

HISTORY OF CURRENT CONDITION:
Have you had a history of problems in the area of question? ☐ Yes ☐ No Date(s) _______/_______/_______

Have you had any of the following types of treatment for the current problem?
☐ Physical Therapy ☐ Occupational Therapy ☐ Massage Therapy ☐ Chiropractor ☐ Cortisone Injections

☐ Pain Clinic ☐ Other: ____

Was it resolved with this treatment? ☐ Yes ☐ No How long did it take? _______________ Function after: _________%

GOAL: What are your goals with Physical Therapy? ____

Name: ____ DOB: ________________

CASE HISTORY: Problem #2 (may be skipped if not more than one area of complaint)

Date of Onset: _______/_______/_______ Onset due to: ______________________________________

CURRENT COMPLAINTS:
☐ Stiffness/Tightness ☐ Tingling ☐ Weakness ☐ Difficulty Walking ☐ Imbalance ☐ Numbness ☐ Severe Pain

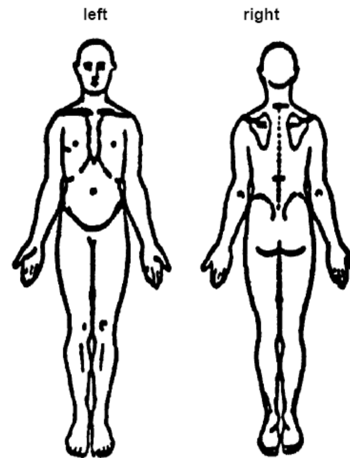
☐ Moderate/Mild Pain ☐ Loss of Function ☐ Other: ______________________

PAIN:
Pain Frequency: ☐ Constant Steady ☐ Constant Variable ☐ Comes and Goes ☐ Occasional ☐ Sporadic ☐ Rare

Pain Quality: (check all that apply) ☐ Aching ☐ Burning ☐ Dull ☐ Pulsing ☐ Stabbing ☐ Steady ☐ Throbbing

Please describe your AREA or BODY PART of pain or complaint________________________________.
(please fill in or circle the area on the bodies below as well)

Pain Rating:
Rate your pain on a scale from 0-10 (0= NO PAIN and 10= WORST PAIN you can imagine)



Your pain today..…………………………………......…...___________.

The BEST it has been since the onset……………………….___________.

The WORST it has been since the onset…………………….___________.

Recent symptom status: ☐ Improving ☐ Unchanged ☐ Worsening

Functional Levels: Prior to onset: _________% Present: ________%

Last time was 100%: ____.

Pain Behavior:
Does time of day affect your symptoms? ☐ Yes ☐ No If yes, describe how. ___________________________

What activities make you BETTER? ____

What activities make you WORSE? ____

What activities are you CURRENTLY UNABLE to do because of your symptoms? ____________________

Current Treatment for this condition include: ____________________________________

Effects of Current Treatment: ____

Diagnostic Testing: ☐ None ☐ X-ray ☐ MRI ☐ Bone Scan ☐ CT Scan ☐ EMG ☐ NCV ☐ Other ___________
*Please bring any and all reports and/or results of any testing or scans related to the current condition.

HISTORY OF CURRENT CONDITION:
Have you had a history of problems in the area of question? ☐ Yes ☐ No Date(s) _______/_______/_______

Have you had any of the following types of treatment for the current problem?
☐ Physical Therapy ☐ Occupational Therapy ☐ Massage Therapy ☐ Chiropractor ☐ Cortisone Injections

☐ Pain Clinic ☐ Other: ____

Was it resolved with this treatment? ☐ Yes ☐ No How long did it take? _____________ Function after: _________%

GOAL: What are your goals with Physical Therapy? ____________________________________

Name: ____ DOB: ______________________

CASE HISTORY: **Problem #3** (if more forms are needed, please make copies or ask for additional forms)

Date of Onset: _______/_______/_______ Onset due to: ____

CURRENT COMPLAINTS:
☐ Stiffness/Tightness ☐ Tingling ☐ Weakness ☐ Difficulty Walking ☐ Imbalance ☐ Numbness ☐ Severe Pain

☐ Moderate/Mild Pain ☐ Loss of Function ☐ Other: ______________________________

PAIN:
Pain Frequency: ☐ Constant Steady ☐ Constant Variable ☐ Comes and Goes ☐ Occasional ☐ Sporadic ☐ Rare

Pain Quality: (check all that apply) ☐ Aching ☐ Burning ☐ Dull ☐ Pulsing ☐ Stabbing ☐ Steady ☐ Throbbing

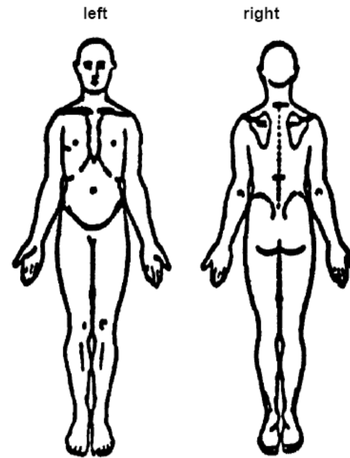
Please describe your AREA or BODY PART of pain or complaint____.
(please fill in or circle the area on the bodies below as well)

Pain Rating:
Rate your pain on a scale from 0-10 (0= NO PAIN and 10= WORST PAIN you can imagine)

Your pain today..………………………………….....…...___________.

The BEST it has been since the onset…………………………___________.

The WORST it has been since the onset……………………..___________.



Recent symptom status: ☐ Improving ☐ Unchanged ☐ Worsening

Functional Levels: Prior to onset: _________% Present: ________%

Last time was 100%: ____.

Pain Behavior:
Does time of day affect your symptoms? ☐ Yes ☐ No If yes, describe how. ______________________________

What activities make you BETTER? ____

What activities make you WORSE? ____

What activities are you CURRENTLY UNABLE to do because of your symptoms? _____________________________

Current Treatment for this condition include: ____

Effects of Current Treatment: ____

Diagnostic Testing: ☐ None ☐ X-ray ☐ MRI ☐ Bone Scan ☐ CT Scan ☐ EMG ☐ NCV ☐ Other _______________
*Please bring any and all reports and/or results of any testing or scans related to the current condition.

HISTORY OF CURRENT CONDITION:
Have you had a history of problems in the area of question? ☐ Yes ☐ No Date(s) _______/_______/_______

Have you had any of the following types of treatment for the current problem?
☐ Physical Therapy ☐ Occupational Therapy ☐ Massage Therapy ☐ Chiropractor ☐ Cortisone Injections

☐ Pain Clinic ☐ Other: ____

Was it resolved with this treatment? ☐ Yes ☐ No How long did it take? ______________ Function after: _________%

GOAL: What are your goals with Physical Therapy? ____

Name: ____ DOB: ________________

ACTIVITY LEVEL:

Occupation: ______________________ Hours worked: ________/day Hours Worked: ________/ week

Current Status: ☐ Full Time ☐ Part Time ☐ Normal Duty ☐ Light Duty ☐ Not Able to Work ☐ Other __________

Maximum Lifting requirements at work: ______________ lbs. At home: ______________lbs.

Domestic Activities: ______________________________Frequency/Duration:________________

Marital Status : ☐ Married ☐ Single ☐ Divorced/Separated ☐ Engaged ☐ Widowed ☐ Other ____________

Number of Children: ______________

Do you participate in a regular exercise program or other recreational activities? ☐ Yes ☐ No

List activities: ______________________________Frequency/Duration:________________

GENERAL HEALTH:

Fitness Level: Poor Fair Good Excellent **Sleep Rating**: Poor Fair Good Excellent

Hours in Bed: ________ Restful Hours: __________

Overall Health Rating: Poor Fair Good Excellent **Nutritional Rating:** Poor Fair Good Excellent

Age: ____________Height: ___________ Weight: ___________ lbs

Have you had Bone Density Testing done? ☐ Yes ☐ No If yes, when? ______________________

MEDICAL HISTORY:

I CURRENTLY HAVE, or HAVE HAD a history of: (check all that apply)

☐ High Blood Pressure ____/____ Last reading	☐ Heart Trouble	☐ Stroke
☐ Poor Circulation	☐ Coronary Artery Disease	☐ Frequent Falls
☐ Shortness of breath	☐ Cancer	☐ Dizziness
☐ Diabetes: Type 1 / Type 2	☐ Bruising Easily	☐ Memory Loss
☐ ________________	☐ ________________	☐ ________________

Females: Are you in menopause or post- menopausal? ☐ Yes ☐ No

Could you be or are you pregnant? ☐ Yes ☐ No If yes, when is the baby due? ______________

Prescription and OTC Medications currently used: ______________________________

____

Allergies: ____

Substance Use: **Tobacco** ☐ Yes ☐ No **Alcohol** ☐ Yes ☐ No **Caffeine** ☐ Yes ☐ No **Drugs** ☐ Yes ☐ No

Frequency ________ Frequency ________ Frequency ________ Frequency ________

Illnesses: ____

Surgeries: ____