NEW PATIENT QUESTIONNAIRE

Name: ______________________ Date: ______________________

Injury Date: ____________ Date of Birth: ____________

Workman's Comp: Yes or No

Who referred you? ____

Reason for attending therapy: ____

Who is your primary care physician? ____

List any drug allergies:

Current medications (including dose and frequency):

Because of your problem, what specific activities are you having difficulty with?

What are your personal goals/outcomes you hope to achieve from therapy?

Please list any surgeries you have had

Any prior Physical Therapy? Yes or No   If so, When: ______________________________

Have you had any of the following? Please indicate the date, where preformed, and type (ie..Cervical, Lumbar)

X-Ray: ____________________

CT Scan: ____________________

MRI: ____________________

Please answer the following questions about your symptoms:

1. Was there an injury or accident that initiated the symptoms? If so What?

2. How would you describe your pain?

DULL PRESSURE ACHING STABBING THROBBING STIFFNESS

SHOOTING BURNING CUTTING PINS/NEEDLES TINGLING ELECTRIC SHOCKS

3. How often do you experience these symptoms?

CONTINUOUSLY DAILY WEEKLY MONTHLY OTHER:

4. Which positions INCREASE your pain?

STANDING SITTING LYING WALKING TWISTING REACHING LIFTING BENDING OTHER

5. Which positions REDUCE your pain?

STANDING SITTING LYING WALKING TWISTING REACHING LIFTING BENDING OTHER

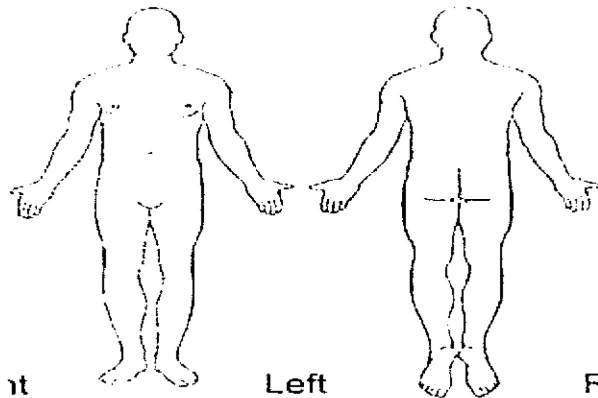
Do you currently have or have a history of the following?

_Anemia _Diabetes _Asthma _Arthritis _Depression _Asthma
_Cancer _Dizziness/Fainting/Falling _COPD _Cardiovascular Problems
_Fractures _Holter Monitor _Headaches _Seizures _Low Blood Pressure
_MRSA _Thyroid Problems _Hepatitis/HIV _Kidney Problems
_Osteoporosis _Currently pregnant

Are you allergic to Latex? Yes or No Dexamethasone? Yes or No Reactions: ____________

Pain Scale :0 1 2 3 4 5 6 7 8 9 10 0 being no pain, 10 being sever pain

Put an X on body where pain is:



Consent to Treatment: I consent to rehabilitation and related services at Physical Restoration and Sports Medicine. In so doing, I understand, acknowledge and affirm that such rehabilitation and related service may involve bodily contact, touching and/or direct contact of sensitive material.

Payment is due at time of service, we accept payment in the form of cash, check, Master Card and Visa. If we are in network, we expect payment in full of any co-pays, deductibles, or co-insurance at the time of your visits. We will file your claim to your insurance company as a courtesy to you. You are responsible for suppling Physical Restoration and Sports Medicine with the proper prescription, referral, authorization in order for you claims to be paid, if you do not supply us with the proper forms and your insurance denies your claims you are responsible for paying the claim in full. Please check with your insurance company to verify your benefits. You are also accountable to know how many visits you have been seen for physical therapy. Most insurance companies have a limit to how many times you can be seen. Please keep a count of those. If we are out of network you are responsible for paying your claims in full at time of service.

We do not file Secondary insurance unless it is secondary to Medicare. We can provide you with necessary paperwork to file on your own. Primary co-pays, deductible, and co-insurance are due at time of service

Liability: I know and agree that Physical Restoration and Sports Medicine is not responsible for loss or damage to personal valuables.

Waiver and Release: I hereby release, discharge and acquit Physical Restoration and Sports Medicine, Its agents, representatives, affiliates, employees, or assigns, of and from any and all liability claim, demand, damage, cause of action , or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and or medical services, including but not limited to ambulance services Emergency Medical Technician, Physician or urgent care services.

No Show/Cancellation/Late Policy: You must give a 24-hour notice if you plan to cancel your appointment. Failure to do so will result in a $50.00 charge. If you are going to be late please contact our office as soon as possible so we can make other arraignments for you. If you no show for an appointment they you will automatically be charged $50.00 for the visit you missed.

Authorization of Payment: I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practice. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment.

Notice of Privacy (HIPPA): I acknowledge receipt of the Notice of Privacy Practice.

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature__________________ Date: ____________________________

Witness Signature___________________________

PATIENT DEMOGRAPHICS

Last Name	First Name	Middle Initial	Social Security #
Address		Email Address	
City	State	Zip Code	Emergency Contact
Home Telephone	Work Telephone	Sex	Emergency Contact Phone Number
Marital Status	Employer	Employer Phone number	

PRIMARY INSURANCE INFORMATION

Primary Insurance Name	Policy Number	Group Number	
Primary Insurance Address	City	State /Zip	Phone Number
Subscriber Name	Date of Birth	Address/City/State/Zip	
Subscriber Employer	Subscriber Work Number		

SECONDARY INSURANCE INFORMATION

(we only file if its secondary to Medicare)

Secondary Insurance Name	Policy Number	Group Number	
Secondary Insurance Address	City	State/Zip	Phone Number
Subscriber Name	Date of Birth	Address/City/State/Zip	
Subscriber Employer	Subscriber Work Number		