Wasilla Physical Therapy

PATIENT INFORMATION

Last Name_____ **First Name**_____ **MI** _____ **M/F** ☐☐

Mailing Address_____ **City** _____ **State** _____ **Zip**_____

Residence/Street _____**City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **DOB**_____ **SSN#**_____

Single____ **Married**_____ **Divorced/Separated** _____**Widowed**_____

Employer _____ **Address** _____**Phone** _____

I would like appointment reminder sent via (circle one) ☐ **E-Mail** _____

☐ **Cell** _____ **Carrier**_____

RESPONSIBLE PARTY

Last Name_____ **First Name**_____ **MI** _____ **M/F** ☐☐

Mailing Address_____ **City** _____ **State** _____ **Zip**_____

Residence/Street _____**City** _____ **State** _____ **Zip** _____

Home Phone _____ **Date of Birth** _____ **Social Security #** _____

Relation to Patient _____

INSURANCE INFORMATION

PRIMARY Insurance _____ **Policy #** _____ **Group #** _____

Insured _____ **DOB** _____ **Social Security #** _____

SECONDARY Insurance _____ **Policy #**_____ **Group #**_____

Insured _____ **DOB** _____ **Social Security #**_____

***Workmans Comp claim #**_____ **Auto Accident claim #** _____ **Date of Injury** _____

GENERAL INFORMATION

Emergency Contact information

Name_____ **Phone/Cell** _____**Relationship** _____

Who referred you to our office? _____ **Referring Physician**_____

Who in your family may we discuss your health care with?

_____

Signed _____**Date** _____

Wasilla Physical Therapy (WPT) FINANCIAL POLICIES

PLEASE REVIEW AND INITIAL

PATIENT NAME _____ DATE _____

- If proof of insurance cannot be provided, payment will be due in full._____
- Private insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, secondary insurance, "usual and customary" charges, etc. other than to supply required information.
- Any balances on your account need to be paid in full before you will be seen again, unless a payment arrangement has been made with the billing personnel._____
- WPT bills secondary insurance only when required by contract: Medicare, Medicaid, Blue Cross, Tricare, and Aetna. _____
- Delinquent account (>90 days) are subject to collections processes which may include the account being transferred to Cornerstone Credit Services (CCS). You will be responsible for any fees and/or commission charged by CCS. Patients whose accounts have been sent to CCS will be discharged from the clinic._____
- WPT will charge a fee of $30.00 for any checks marked NSF from the bank. It is also the policy of WPT that the patient's account be flagged until the debt has been repaid. Remittance should be in the form of cash, credit card, or money order along with the NSF Fee._____
- Any appointment cancelled less than 24 hours prior to the scheduled appointment time is subject to a $40.00 appointment cancellation fee._____
- I hereby assign all medical benefits to which I am entitled including Medicare, private insurance, PPO plans, Medicaid, RR Medicare, and all other health plans to Wasilla Physical Therapy. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance (including Medicaid). I hereby authorize assignee to release all information needed to secure the payment, and necessary medical correspondence required for treatment.

Signed _____ Date _____

Name: _____ DOB: _____

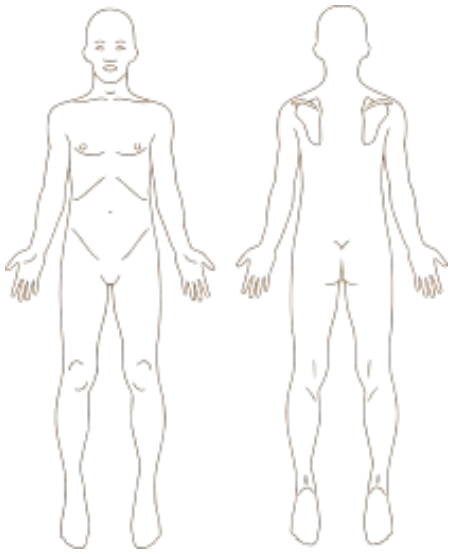
Reason for PT:_____

Approximate Date of Onset: _____ Surgery for this incident? (☐) Yes (☐) No

Recent Imaging? (circle one) X-ray MRI CT scan
Results?_____

Presently working: (☐) Yes (☐) No Occupation:_____

Hobbies/Activities you enjoy:_____



Pain: 0 (no pain), 10 (absolute worst pain):

At best_____ At worst:_____

Please indicate where your pain is located on the diagram:

Other Complaints? (☐) Numbness/tingling
(☐) Swelling
(☐) Stiffness
(☐) Weakness

Any falls in the past year? (☐) Yes (☐) No If so, how many in the past month? _____

Marital Status: _____ Pets: _____ Live alone? (☐) Yes (☐) No

Goal for PT:_____

Medical History (**Circle** whether this is an **Active- A** OR **Past- P** history)

- ☐ Diabetes
- ☐ Cardiac Conditions (A / P)
- ☐ High Blood Pressure (A / P)
- ☐ Stroke (A / P)
- ☐ Epilepsy/Seizures (A / P)
- ☐ Urinary Tract Infection (A / P)
- ☐ Incontinence (A / P)
- ☐ Current Open Wounds
- ☐ Skin Conditions (A / P)
- ☐ Hepatitis (A / P)
- ☐ Contagious Disease (A / P)
- ☐ HIV/AIDS
- ☐ Anemia (A / P)
- ☐ Currently Pregnant
- ☐ Anxiety/Depression (A / P)
- ☐ High Cholesterol (A / P)
- ☐ Thyroid disease (A / P)
- ☐ Cancer (A / P)
- ☐ Heart Murmur (A / P)
- ☐ Lung Disease (A / P)
- ☐ Dizziness (A / P)
- ☐ Kidney Disease (A / P)
- ☐ Asthma (A / P)
- ☐ Pacemaker
- ☐ Eye Surgery/Disease(A / P)
- ☐ Osteoporosis
- ☐ Headaches/Migraines(A / P)
- ☐ MRSA (A / P)
- ☐ GI Problems (A / P)
- ☐ Tuberculosis (A / P)
- ☐ Blood Clots (A / P)
- ☐ Arthritis (A / P)
- ☐ Concussion (A / P)
- ☐ Brain injury (A / P)
- ☐ Other: _____

Patient Name: _____

Tobacco use: (☐) Yes (☐) No
Alcohol use: (☐) Yes (☐) No
Drug use (specify): _____

MEDICATION LIST: (include name of drug, dosage, and prescribing physician; if you carry a printed list of your medication list, we can make a photocopy)

_____
_____
_____
_____
_____
_____
_____
_____

SURGICAL HISTORY: (include approximate date of surgery)

_____
_____
_____
_____
_____
_____
_____
_____

HOSPITALIZATIONS: (include approximate date and reason)

_____
_____
_____
_____
_____

Name: _____

Date: _____

OPTIMAL INSTRUMENT
Difficulty – Baseline

Instructions: Please Mark an **"X"** for the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat						
2. Rolling over						
3. Moving–lying to sitting						
4. Sitting						
5. Squatting						
6. Bending/Stooping						
7. Balancing						
8. Kneeling						
9. Standing						
10. Walking – Short Distance						
11. Walking – Long Distance						
12. Walking – Outdoors						
13. Climbing Stairs						
14. Hopping						
15. Jumping						
16. Running						
17. Pushing						
18. Pulling						
19. Reaching						
20. Grasping						
21. Lifting						
22. Carrying						

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. 13 2. 8 3. 14 *)*

1. ____ 2. ____ 3.____

24. From the above list of three activities, choose the primary activity you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs* without any difficulty, you would choose: Primary goal. *13*)

Primary goal. ____