

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: _____

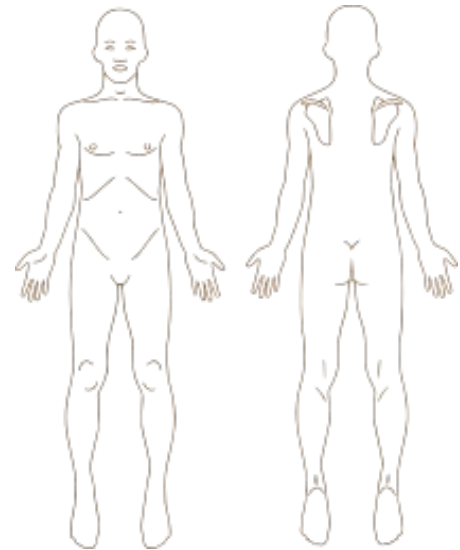
Hobbies/Activities you enjoy: _____

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)

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

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 <i>climb stairs</i> , <i>kneel</i> , and <i>hop</i> without any difficulty, you would choose: 1. <u>13</u> 2. <u>8</u> 3. <u>14</u>) 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 <i>climb stairs</i> without any difficulty, you would choose: Primary goal. <i>13</i>) Primary goal. ____ | | | | | | |