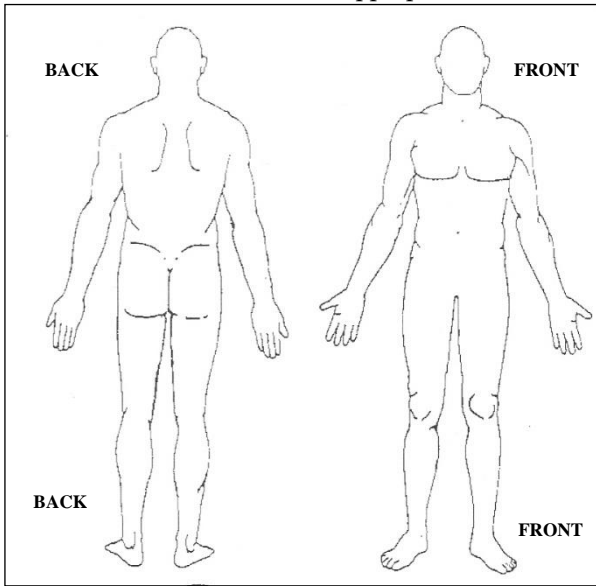


TO ENSURE YOU RECEIVE A COMPLETE AND THOROUGH EVALUATION, PLEASE PROVIDE US WITH IMPORTANT INFORMATION ON THIS FORM. IF YOU DO NOT UNDERSTAND THE QUESTION, PLEASE ASK FOR ASSISTANCE. THANK YOU.

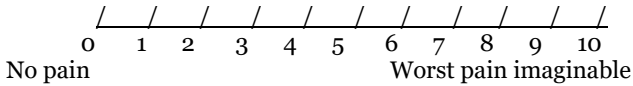
HISTORY OF PRESENT CONDITION

1. What are your symptoms? _____

Localize areas of pain or abnormal sensation on the body chart below (shade where appropriate)



2. Please indicate on the scale below the worst your pain has been in the last 24 hours.



3. When did your symptoms begin? _____
 (Please indicate a specific date if possible.) If surgery or accident, please indicate date _____

4. Which of the following best describes how your injury occurred? (If your condition is post surgical, please indicate as per your original injury.)

- lifting degenerative process overuse
- car accident recreation/sports
- trauma/accident other _____

5. Since onset, have your symptoms:

- improved worsened not changed

6. Have you had similar symptoms in the past? yes no
 How many episodes? _____

7. Check all that apply to describe the nature of your symptoms.

- burning tingling numb cramping
- sharp dull aching throbbing
- occasional constant periodic
- other _____

8. As the day progresses, do your symptoms:

- worsen improve remain the same

9. In what position do you sleep?

- right side left side stomach
- back back/sides/stomach chair/recliner

10. What aggravates your symptoms?

- sitting standing up/down stairs
- walking sleeping sitting to standing
- squatting stress standing to sitting
- coughing/sneezing reaching across body
- reaching overhead reaching behind back
- taking a deep breath reaching in front of body
- bending looking overhead
- household activities recreational activities
- other _____

11. What relieves your symptoms?

- heat sitting standing
- cold/ice rest stretching
- walking medication massage
- exercise lying down nothing
- other _____

12. Check previous treatments you have had for this condition.

- none oral medication
- exercise TENS unit biofeedback/hypnosis
- traction bracing/taping/casting
- bed rest acupuncture spinal/muscle injection
- chiropractic physical therapy
- hospitalization/dates _____

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PATIENT QUESTIONNAIRE/HEALTH HISTORY

Name _____

Date _____ Ref MD _____



13. Check any of the following diagnostic tests that you have had performed for this current condition.

- none
- x-ray
- MRI
- other _____

14. What are your goals from physical therapy?

15. Do you have a specific time frame in mind for reaching these goals? yes no

How long? _____ days weeks months

16. In order to get better, you will be expected to participate in your treatment. This may include doing exercises (here and/or at home) or avoiding certain activities. How committed are you to participating in your treatment?

- very
- somewhat
- not very

MEDICATION

Please list any prescription medications that you are currently taking (pain pills, injection, skin patches, etc.) Attach a separate sheet if necessary _____

List any over the counter medications that you are currently taking _____

ALLERGIES/PRECAUTIONS

List any allergies to food, medications or topical agents: _____

Are you, or could you be, pregnant? yes no

Do you have a pacemaker or other implantable device?

- yes
- no

Other conditions/situations that may affect your care or progress: _____

WORK HISTORY

Occupation _____

- employed full time
- employed part time
- self employed
- homemaker
- student
- retired
- unemployed

Does this condition affect your work status in any way?

- yes
- no

Physical activities at work (check all that apply)

- sitting
- standing
- phone use

heavy lifting driving repetitive bending

computer use heavy equipment operation

other _____

Are you currently receiving or seeking disability for this condition? yes no

If not performing your normal activities at work, do you plan to return to your previous activity level? yes no

LIVING SITUATION

live alone live with: _____

private home with stairs private home, no stairs

assisted living

Emergency contact name: _____

Emergency contact phone: _____

GENERAL HEALTH

How would you rate your general health?

excellent average poor

Do you exercise outside of normal daily activities? no

3+ days/week 1-3 days/week rarely

Exercise, sports/recreation consisting of _____

Do you drink caffeinated beverages? yes no

Do you smoke? yes no *packs per day* _____

What is your stress level? low medium high

PAST MEDICAL/PAST FAMILY HISTORY

Have you (P) or an immediate family member (F) ever been diagnosed with any of the following conditions?

arthritis **P F** osteoporosis **P F**

headaches **P F** stroke **P F**

heart problems **P F** high blood pressure **P F**

cancer **P F** (type) _____

epilepsy/seizures **P F** Parkinson's **P F**

diabetes **P F** kidney problems **P F**

thyroid problems **P F** circulatory problems **P F**

depression **P F**

List any surgeries you have had related to your current problem.

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PATIENT _____

SOC _____ **REF MD** _____

ADVANCE PHYSICAL THERAPY

SYSTEMS REVIEW

Since onset of this current condition, have you experienced any of the following symptoms (either new or aggravation of chronic problem)? Check all that apply.

- General** fever chills weight changes fainting appetite changes lethargy sleep changes fatigue
- Musculoskeletal** joint pain muscle pain muscle cramps fractures swelling arthritis weakness
- Neurological** dizziness tremors lack of coordination/balance tension headaches numbness/tingling
- Cardiovascular** chest pain shortness of breath irregular pulse hypertension numbness of extremities
- Respiratory** wheezing asthma shortness of breath cough
- Gastrointestinal** nausea vomiting heartburn painful bowels diarrhea constipation abdominal pain
- Genitourinary** urinary pain urinary frequency burning on urination sexual difficulty incontinence
- Integumentary (skin)** rashes sores scars pain masses/lumps
- Endocrine** sweating voice changes thirst
- Eyes** pain spots twitching blurred vision
- Ears, nose, mouth, throat** pain nose bleeds sores noise sensitivity ringing in ears
- Psychiatric** depression anxiety emotional instability memory loss
- Hematologic/Lymphatic** bruising fatigue enlarged glands phlebitis anemia

FUNCTIONAL ASSESSMENT - BASELINE

<i>Please circle the level of difficulty you have TODAY for each of the activities listed below.</i>	Able to do without difficulty or pain	Able to do with little difficulty or pain	Able to do moderate difficulty or pain	Able to do with much difficulty or pain	Unable to do	Comments
Lying flat	1	2	3	4	5	
Rolling over	1	2	3	4	5	
Lying to sitting	1	2	3	4	5	
Sitting	1	2	3	4	5	
Sitting to standing	1	2	3	4	5	
Standing to sitting	1	2	3	4	5	
Squatting	1	2	3	4	5	
Bending/stooping	1	2	3	4	5	
Balancing	1	2	3	4	5	
Kneeling	1	2	3	4	5	
Walking-short distance	1	2	3	4	5	
Walking- long distance	1	2	3	4	5	
Climbing stairs (single step)	1	2	3	4	5	
Climbing stairs (more than 5)	1	2	3	4	5	
Going down stairs	1	2	3	4	5	
Walking outdoors – uneven terrain	1	2	3	4	5	
Sleeping	1	2	3	4	5	
Transitional movements	1	2	3	4	5	
Pushing	1	2	3	4	5	
Pulling	1	2	3	4	5	
Reaching out front	1	2	3	4	5	
Reaching overhead	1	2	3	4	5	
Reaching back	1	2	3	4	5	
Grasping	1	2	3	4	5	
Lifting	1	2	3	4	5	
Carrying	1	2	3	4	5	
Personal care (washing, dressing)	1	2	3	4	5	
Driving	1	2	3	4	5	
Hopping/Jumping	1	2	3	4	5	
Running	1	2	3	4	5	

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PATIENT _____ **SOC** _____ **REF MD** _____

ADVANCE PHYSICAL THERAPY



9362 W. Overland Road • Boise, Idaho 83709 • (208) 672-8144 • Fax (208)672-8145

BILLING AND INSURANCE POLICIES OF ADVANCE PHYSICAL THERAPY

INSURANCE BILLING POLICY

We are pleased to offer you our insurance billing service. We accept Medicare and Medicaid assignment, and are participating members of many insurance plans. We will file insurance claims on your behalf with your insurance programs. We will also bill Worker’s Compensation, auto insurance, and will accept liens with your attorney. As such, we will require a copy of your current insurance ID card(s) and completion of all required paperwork. Without this information, we will be unable to assist you in the billing process. Please keep us informed of any changes to your personal and/or insurance information.

***APT is required by law to collect deductibles, co-payments and cost shares when these are part of your insurance plan/contract. Payment is expected at the time of service unless other arrangements have been made.** We will strive to collect payment directly from your third party payer, but please keep in mind that patients are ultimately responsible for their bills, not just co-payments, deductibles, and any cost shares. You will receive periodic statements on your account that may not reflect insurance payments as these may still be pending. However, unpaid co-pays and cost shares reflected on statements should be promptly remitted.*

PAYMENT OPTIONS

In recognition that resources for health care are often limited, APT offers these payment options:

- Payment by cash, check, money order or credit card (MasterCard or Visa)
- Payment plan arranged with office manager
- Request for financial hardship adjustment (requires additional paperwork)

LATE PAYMENTS/NO SHOWS/CANCELLATIONS/RETURNED CHECKS

Any balances not paid in a timely manner (typically within 60 days) may be subject to finance charges (1.5% per month - 18% annually), collection procedures, or other legal processes. A \$40.00 fee will be charged for missed appointments and may be charged for cancellations when less than 24 hour notice is provided. A \$20.00 fee will be charged for returned checks.

ASSIGNMENT OF BENEFITS

I, the undersigned, authorize payment of medical benefits to Advance Physical Therapy/Alvin L. Jones, P.T. for any services furnished to me by the care providers of said practice. I assign all rights, benefits and claims I may have under any policy of insurance (major medical, liability, worker’s compensation, and any other) and the proceeds from any claim that I may have. *This assignment authorizes direct payment to Advance Physical Therapy/Alvin L. Jones, P.T.*

RESPONSIBLE PARTY STATEMENT

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility. I understand that I am responsible for my deductible and any co-payments and non-covered services or supplies. In the event that my account becomes delinquent, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of debt. I have read and understand the billing policies of Advance Physical Therapy.

Patient/Responsible Party Signature _____ **Date** _____

Printed Name _____

WELCOME TO ADVANCE PHYSICAL THERAPY

Please take a few moments to complete this form in its entirety. All information will be considered confidential and will be released only as allowed through HIPAA regulations, and as considered necessary for treatment, payment, or other health care operations.

LAST Name _____ FIRST Name _____ MI _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Work # _____ Cell # _____

EMAIL ADDRESS _____

Date of Birth _____ SSN _____ Sex M F

Race Asian Black Caucasian Other Pacific Islander Decline

Language English Spanish Other Ethnicity Hispanic Non-Hispanic Decline

Emergency Contact _____ Relationship _____ Phone _____

Marital Status (check one) Minor Single Married Divorced Widowed Separated

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____ Work Phone _____

How did you hear about our office? Physician Former Patient Phone Book Other

Referring Physician _____ Primary Care Physician _____

Accident Related? Yes No Type Auto Work Other Date of Injury _____

Work Comp Case Worker _____ Phone _____

Lawyer (if applicable) _____ Phone _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION *(Complete this section only if information is different from patient)*

Name of person responsible for this account _____

Relationship to patient _____ Daytime Phone _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Employer _____

INSURANCE INFORMATION

Primary Insurance Carrier _____ Insured Name _____ Relationship to patient _____ Policy/ID# _____ Group # _____ Insured Date of Birth _____ Insured's Employer _____	Secondary Insurance Carrier _____ Insured Name _____ Relationship to patient _____ Policy/ID# _____ Group # _____ Insured Date of Birth _____ Insured's Employer _____
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CONSENT TO TREAT/ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION

I consent to evaluation and treatment by authorized personnel of APT as may be dictated by prudent medical practice for my (or my dependent's) illness, injury, or condition. I authorize APT to bill the insurance carrier(s) or other third party payor named above and authorize assignment of benefits directly to APT. I also authorize release of medical information for the purposes of treatment, payment, or other health care operation for my case. (Refer to APT Billing Policy Statement).

PATIENT/RESPONSIBLE PARTY SIGNATURE _____ DATE _____

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PATIENT _____	ACCT# _____	SOC DATE _____
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