PATIENT INFORMATION

LAST NAME: FIRST NAME: MIDDLE INITIAL:
ADDRESS: APT: CITY: STATE: ZIP:
HOME PHONE: CELL PHONE: EMAIL ADDRESS:
SEX F M BIRTHDATE: AGE: SS#: MARITAL STATUS:
EMERGENCY CONTACT: EMERGENCY CONTACT PHONE #

REFERRAL SOURCE

REFERRING MD: PHONE #:
FRIEND OR FAMILY REFERRAL: OTHER:

WORK INFORMATION

EMPLOYER NAME:
EMPLOYER ADDRESS: CITY: STATE: ZIP:
EMPLOYER CONTACT:
OCCUPATION: WORK PHONE #:

INJURY INFORMATION

ACCIDENT RELATED: Y N TYPE: [ ] WORK [ ] AUTO [ ] OTHER
DATE OF INJURY: HOW INJURY OCCURRED:

INSURANCE INFORMATION

PRIMARY INSURANCE: POLICY / GROUP #:
SECONDARY INSURANCE: POLICY / GROUP #:

INSURED / RESPONSIBLE PARTY INFORMATION

LAST NAME: FIRST NAME: MIDDLE INITIAL:
ADDRESS: CITY: STATE: ZIP:
RELATIONSHIP TO PATIENT: [ ] SELF [ ] SPOUSE [ ] CHILD [ ] OTHER
BIRTHDATE: AGE: SS#:
HOME PHONE: WORK PHONE:
EMPLOYER NAME:
EMPLOYER ADDRESS:

ATTORNEY / AUTO INSURANCE INFORMATION

ATTORNEY NAME: PHONE #: FAX #:
AUTO INSURANCE: PHONE#:
ADJUSTER'S NAME: CLAIM #:

INSURANCE ASSIGNMENT AND RELEASE

I hereby authorized **Achieve Physical Therapy** to furnish information to the insurance carrier(s) concerning my treatment and hereby assign to the therapist(s) all payments for the service rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment.

Signature: ______________________________ Date: ______________

[ ] We would love to keep you informed with home exercise programs and updated information about our office. If you **do not want** to hear from us, please check the box.

ACHIEVE
PHYSICAL THERAPY

PATIENT QUESTIONNAIRE / HEALTH HISTORY

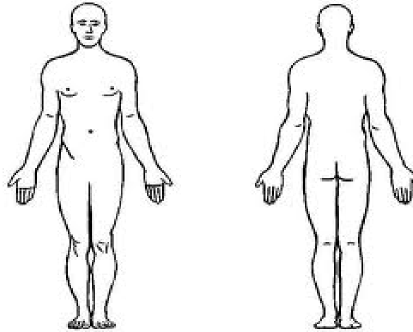
Patients Name: Date:

HISTORY OF PRESENT CONDITION

1. What are your symptoms? ____

____

Local areas of **pain** or **abnormal** sensation on the body chart below. Shade in where appropriate)



2. When did your symptoms begin? (Please indicate a specific date if possible) ________________________
3. Was the onset of this episode gradual or sudden?(check one) **[ ] Gradual** **[ ] Sudden**
4. How did your injury/ pain/ symptoms occur? ____
5. Was this a **work** related injury? **[ ] Yes** **[ ] No**
6. Since onset, are your symptoms getting: (Check one) **[ ] Better** **[ ] Worse** **[ ] Not Changing**
7. Have you had similar symptoms in the past? **[ ] Yes** **[ ] No**

   If so, more than one episode? **[ ] Yes** **[ ] No** How long ago? ________________________
8. What aggravates your symptoms? (Check all that apply)

   [ ] Sitting [ ] Going to/ rising from sitting [ ] Walking [ ] Laying Down
   [ ] Up/ down stair [ ] Reaching overhead [ ] Reaching behind back [ ] Reaching in front of body
   [ ] Reaching across body [ ] Recreation / Sports [ ] Standing [ ] Squatting
   [ ] Sleeping [ ] Coughing / Sneezing [ ] Taking deep breath [ ] Swollowing
   [ ] Repetitive activities including: ____
   [ ] Household activities including: ____
   [ ] Other: ____
9. What relieves your symptoms? (Check all that apply)

   [ ] Sitting [ ] Heat [ ] Ice/ cold [ ] Stretching
   [ ] Rest [ ] Standing [ ] Walking [ ] Exercise
   [ ] Laying Down [ ] Massage [ ] Medication [ ] Wearing Splint/ Orthotics
   [ ] Nothing [ ] Other: ____
10. Have you had any of the following tests?

   [ ] X-rays [ ] CT Scan [ ] MRI [ ] Arthrogram
   [ ] Stress x-ray Test [ ] Bone Scan [ ] NCS [ ] Fluoroscope
   [ ] Vestibular [ ] Other: ____

MEDICATION

1.Please list any prescription medications you are currently taking (pain pills, injections an/or skin patches, etc.): ______

____

____

Prescribing MD: ________________ Phone #: ________________________

2. Are you currently taking any of the following over the counter medications? (check all that apply)

   [ ] Aspirin [ ] Advil [ ] Tylenol [ ] Motrin
   [ ] Ibuprofen [ ] Corticosteroids [ ] Antihistamines [ ] Vitamins/ mineral supplements
   [ ] Other: ____

PREVIOUS FUNCTIONAL LEVEL

[ ] **Independent in ALL activities** (work, community, home, recreation)

[ ] **Self-Care**

- [ ] Independent in all self-care activities
- [ ] Difficulty performing self-care activities
- [ ] Need assistance with self-care activities
- [ ] Difficulty performing household chores

[ ] **Social**

- [ ] Need assistance with activities in community outside of home

Hobbies: ______________________________

WORK HISTORY

1. Occupation**:** ______________________________

[ ] Employed full time [ ] Employed part time [ ] Self employed [ ] Homemaker
[ ] Student [ ] Retired [ ] Unemployed [ ] Other: ______________

2. Physical activities at work (Check all that apply)

[ ] Sitting [ ] Standing [ ] Phone use [ ] Repetitive lifting
[ ] Heavy lifting [ ] Computer use [ ] Driving [ ] Heavy equipment operation
[ ] Other: ______________________________

3. Are you currently receiving or seeking disability for this condition? **[ ] Yes** **[ ] No**

4. 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 family members/others [ ] Live with caregiver [ ] Home/ apartment
[ ] Assisted Living [ ] Retired complex (SNF/ ICF) [ ] Other: ______________

Setting

[ ] Stairs with railing [ ] Stairs without railing [ ] No stairs [ ] Ramp
[ ] Elevator [ ] Uneven ground [ ] Other: ______________

GENERAL HEALTH

1. How would you rate your general health?

[ ] Excellent [ ] Average [ ] Poor [ ] Good [ ] Fair

2. Do you exercise outside of normal daily activities?

[ ] 5+ days/wk [ ] 3-4 days/wk [ ] 1-2 days/wk [ ] Occasionally [ ] None

Exercise, sports/ recreation consisting of: ______________________________

____

3. Do you drink caffeinated beverages? **[ ] Yes** **[ ] No** How many/much per day: ______________

4. Do you Smoke? **[ ] Yes** **[ ] No** How many/much per day: ______________

5. What is your stress level?

[ ] Low [ ] Medium [ ] High

6. Are you seeing any health care providers other than the physical therapist for this current condition? ______________

____

Past Medical History

1. Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

[ ] Cancer (type)__________ [ ] Depression [ ] Stroke [ ] Kidney problems [ ] Thyroid problems
[ ] Multiple Sclerosis [ ] Diabetes [ ] Arthritis [ ] Head injury [ ] Stomach problems
[ ] Parkinson's Disease [ ] High BP [ ] Allergies [ ] Blood disorder [ ] Infectious disease
[ ] Heart problem [ ] Osteoporosis [ ] Broken Bone [ ] Epilepsy/ Seizures [ ] Lung problem
[ ] Circulation/ vascular problems [ ] others: ______________________________

2. Please list any recent/ relevant past surgeries related to your current problem (List type of surgery and date):

____

FAMILY HISTORY

1. Has anyone in your immediate family (parents and siblings) ever been treated for any of the following?

[ ] Diabetes [ ] Heart Disease [ ] High BP [ ] Stroke [ ] Cancer [ ] Arthritis
[ ] Osteoporosis [ ] Psychological condition [ ] Other: ______________________________

Financial Policy

For those patients covered by insurance, we will accept assignment of benefits. As a courtesy, we verify and file claims to your insurance company. WE DO NOT GUARANTEE PAYMENT. If you do not inform us of your current insurance or fail to provide the insurance company with updated information, you voluntarily waive your rights to use your insurance with Achieve Physical Therapy at any time. You will be asked to pay your deductible, co-insurance or co-payment the day services are rendered. We will estimate as closely as possible your coverage based on the information we are given by your insurance, but until we actually receive the payment from the insurance company, it is just an estimate. Additionally, you are responsible for any outstanding balances due to Achieve Physical Therapy.

MEDICARE PATIENTS- The Medicare physical therapy calendar year cap for 2023 is $2150. Medicare patients without a secondary or supplement insurance will have an estimated $20/visit co-insurance.

AGREEMENT OF FINANCIAL RESPONSIBILITY- All expenses incurred by Achieve Physical Therapy in the collection of delinquent balances are your responsibility. Including the following:

- Return Check Fees
- Attorney's Fees
- Court Costs
- Filing Fees
- Collection Agency Charges and Commission Fees
- Collection Fees will be 40% for regular collections and 50% for legal collections or forwards, which may be as much as twice the original principal balance owed.
- Interest Rate of 2% per month, 24% per year from 1st date of delinquency.

AGREEMENT OF FINANCIAL RESPONSIBILITY- I have read the above. I UNDERSTAND THAT I WILL BE FINANCIAL RESPONSIBLE FOR ALL OUTSTANDING CHARGES NOT PAID BY MY INSURANCE COMPANY.

Patient's Signature: ____________________________ Date: ________________

Parent Signature (if Minor):_______________________ Date: _______________

DRY NEEDLING CONSENT TO TREAT FORM

Dry needling (DN) is a skilled technique performed by a physical therapist using a single-insertion, sterile filiform needle, which is used to penetrate the skin or underlying tissue to effect change in body conditions, pain, movement, impairment and disability. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving your consent for dry needling treatment.

Risks of procedure:

The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may require a chest X-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture, while rare, may require hospitalization.

Other risks may include bruising, infection or nerve injury. It should be noted that bruising is a common occurrence and should not be a concern. The monofilament needles are very small and do not have cutting edge; the likelihood of any significant tissue trauma from DN is unlikely. There are other conditions that require consideration so please answer the following questions:

- **Are you taking blood thinners? Yes / No**
- **Are you or is there a chance you could be pregnant? Yes / No**
- **Are you aware of any problems or have any concerns with your immune system? Yes / No**
- **Do you have any known disease that can be transmitted through bodily fluids? Yes / No**

Patient's Consent:

I have read and fully understand this consent from and attest that no guarantees have been made on the success of this procedure related to my condition. I am aware that multiple treatment sessions may be required, thus this consent will cover this treatment as well as subsequent treatments by this facility. All of my questions, related to the procedure and possible risks, were answered to my satisfaction.

My signature below represents my consent to the performance of dry needling and my consent to any measures necessary to correct complications, which may result. I am aware I can withdraw my consent at any time.

I, ___________________________________**authorize** the performance of Dry Needling.

____ Date______________
Patient or Authorized Representative

____ Date______________
Relationship to patient (if other than patient)

I, ___________________________________ **refuse** the performance of Dry Needling.

____ Date______________
Patient or Authorized Representative

____ Date______________
Relationship to patient (if other than patient)

SOCIAL MEDIA / PHOTO CONSENT FORM

I,___________________________________, hereby give Achieve Physical Therapy, and any and all employees of Achieve Physical Therapy, the right and permission to take and use and/or publish photographs, videos or other media of me for promotional purposes including but not limited to, marketing, advertising, social media, website, newsletters, brochures, emails and general publications.

_____ I hereby waive any right to inspect or approve the finished product. Additionally, I waive any right to royalties or other compensation arising or related to the use of my photograph, videos or other media.

_____ I understand that I can revoke this release at any time in writing and the use of my photographs or other information authorized by this release will immediately cease.

_____ I understand that revoking this release does not include anything previously used by the authorization of this release.

OR

I,___________________________________, **DO NOT** consent to this release and requested that no photographs, videos or other media be taken of me.

Signature: ____________________________________

Date: ____________________

Notice of HIPAA Information Practices

This notice describes how medical information about you may be disclosed and how you can get access to the information. Please review it carefully.

Achieve Physical Therapy's Legal Duty

Achieve Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Achieve Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; providing your referring physician or appropriate health care provider with copies of reports that should assist him or her in assessing your plan of care; conducting internal administrative activities and evaluating the quality of care that we provide.

Other forms of Disclosure

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representatives or another person responsible for your care, location and general condition.

Marketing: We may contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Federal and State Agencies: As required by law we may disclose health information to public health or legal authorities charged with preventing or controlling diseases, injury or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to valid subpoenas.

Achieve Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosure at any time.

Patient's Individual Rights

You have the right to obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Achieve Physical Therapy will consider all such requests on a case by case basis, but our practice is not legally required to accept them.