Welcome to Active Solutions Physical Therapy

Thank you for selecting **Active Solutions Physical Therapy**. We will strive to provide you with excellence in service. We are dedicated to giving each patient a personal service that they can rely on and trust. To help us meet your needs please fill out this form completely. If you have any questions or need help, please ask- we will be happy to assist you.

Patient Information

Name: Last_____ First _____MI _____
Date:_____**(** Legal Guardian / Responsible Party: _____ __DOB____ ___ **Relation**)
Current address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: H_____ W _____ cell _____
Social Security:_____ □ **Male** □ **Female** □ **Student** □ **Single** □ **Married**
Date of Birth: **month** _____ **day** _____ **year** _____ **Email:** _____
Permanent Address:_____
City: _____ **State:** _____ **Zip:** _____
Employer:_____**Occupation:**_____

General Information

Referring Doctor:_____ **Family Doctor:**_____
Description of Problem: _____
Ongoing Problem/ injury? _____ Work Accident: _____ Auto:_____Other:_____
Medical/ Health Insurance (also complete if MVA):
Insurance company _____ □ PPO □ HMO Other_____
Policy/ID Number _____ Phone Number _____
DOB of the Policy Holder: month:_____ day: _____ year: _____

If Work Comp: Claim Number_____ Date of Onset _____
Adjusters Name_____ Phone Number_____
Insurance Company Name_____
Address _____

If Auto: Type of Accident _____ Date of Accident _____
Has Fault Been Established? Yours _____ Other _____
Auto Insurance Company _____
Adjuster: _____ Phone Number _____ Claim Number _____

Legal Information
Do you have an Attorney? _____ May we have permission to speak with him/her regarding your treatment and payment at Active Solutions Physical Therapy? □ Yes □ No
If Yes, Name _____ Phone Number _____

Emergency Contact:_____ **Phone Number:**_____ **Relationship:**_____

Medical Release of Information: I authorize the release of any medical information necessary to process this claim.

Assignment of Benefits: I hereby assign payment directly to *Flatirons Practice Management*, who represents Active Solutions Physical Therapy to Payor Groups. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand that if this is a motor vehicle accident and the medical benefits are exhausted such that financial responsibility reverts to my health insurance, I am financially responsible for any applicable deductibles or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered.

Signature _____ **Date** _____

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

NAME:_____ LEISURE ACTIVITIES:_____

OCCUPATION: _____

ALLERGIES: List any medication(s) you are allergic to: _____

Are you latex sensitive? Yes No List any other allergies we should know about_____

Have you declared the Advance Clinical Directive of Do Not Resuscitate? Yes No

Please check (√) any of the following whose care you're under"

____ Medical Doctor (MD) _____ Psychiatrist/Psychologist/Counselor Other _____
____ Osteopath (DO) _____ Physical Therapist _____
____ Dentist _____ Chiropractor

If you have seen any of the above in the past three months, please describe for what reason (illness, medical condition, physical, etc.)

_____
_____

Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer
YES NO Heart Problems
YES NO High Blood Pressure
YES NO Circulation Problems
YES NO Asthma
YES NO Emphysema
YES NO Bronchitis
YES NO Chemical dependency (i.e. alcoholism)
YES NO Hyperthyroidism
YES NO Hypothyroidism
YES NO Rheumatoid Arthritis
YES NO Other arthritic conditions

YES NO Diabetes
YES NO Depression/Anxiety/Mental Illness
YES NO Multiple Sclerosis
YES NO Stroke
YES NO Tuberculosis
YES NO Hepatitis
YES NO Depression
YES NO Kidney disease
YES NO Anemia
YES NO Epilepsy
YES NO Osteoporosis/Osteopenia
YES NO Other

For women: Are you currently pregnant or think you might be pregnant? YES NO

Please explain ALL "yes" answers:_____
_____
_____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

	DATE	REASON FOR SURGERY/HOSPITALIZATION			
1.	_____	_____	2.	_____	_____
3.	_____	_____	4.	_____	_____
5.	_____	_____	6.	_____	_____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, and sprains) and the approximate date of injury:

	DATE	INJURY			
1.	_____	_____	2.	_____	_____
3.	_____	_____	4.	_____	_____
5.	_____	_____	6.	_____	_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES NO Diabetes
YES NO Tuberculosis
YES NO High Blood Pressure
YES NO Stroke
YES NO Mental Illness
YES NO Kidney disease
YES NO Cancer. If YES, describe what kind:_____
YES NO Heart Problems. If YES, please describe:_____
YES NO Anemia
YES NO Epilepsy
YES NO Chemical dependency (i.e. alcoholism)

Which of the following OVER-THE COUNTER medications have you taken in the last week?

YES NO Aspirin
YES NO Advil/Motrin/Ibuprofen
YES NO Decongestants
YES NO Antacid
YES NO Tylenol
YES NO Laxatives
YES NO Antihistamines
YES NO Vitamins/Minerals/Supplements
YES NO Other: _____

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

	NAME	DOSAGE	FREQUENCY	ROUTE (how you take the medication)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

How much caffeinated coffee or caffeine containing beverages do you drink per day?_____

How many days per week do you smoke cigarettes/cigars/tobacco? _____ How much ? _____

How many days per week do you drink alcohol? _____

If one drink equals 12 oz. of beer, 5 oz. of wine, or 1.5 oz. of liquor, how much do you drink at an average sitting? _____

How many days per week do you use marijuana? _____ How much?_____

How many days per week do you use other drugs (cocaine, methamphetamine, ecstasy, etc.)? _____

Which drugs do you use? _____ How much?_____

Have you recently noted?

YES NO Weight loss/gain
YES NO Nausea/vomiting
YES NO Fatigue
YES NO Weakness
YES NO Fever/Chills/Sweats
YES NO Numbness or tingling

_____FOR OFFICE USE _____

Weight: _____ kg Height: _____ m

BMI: _____

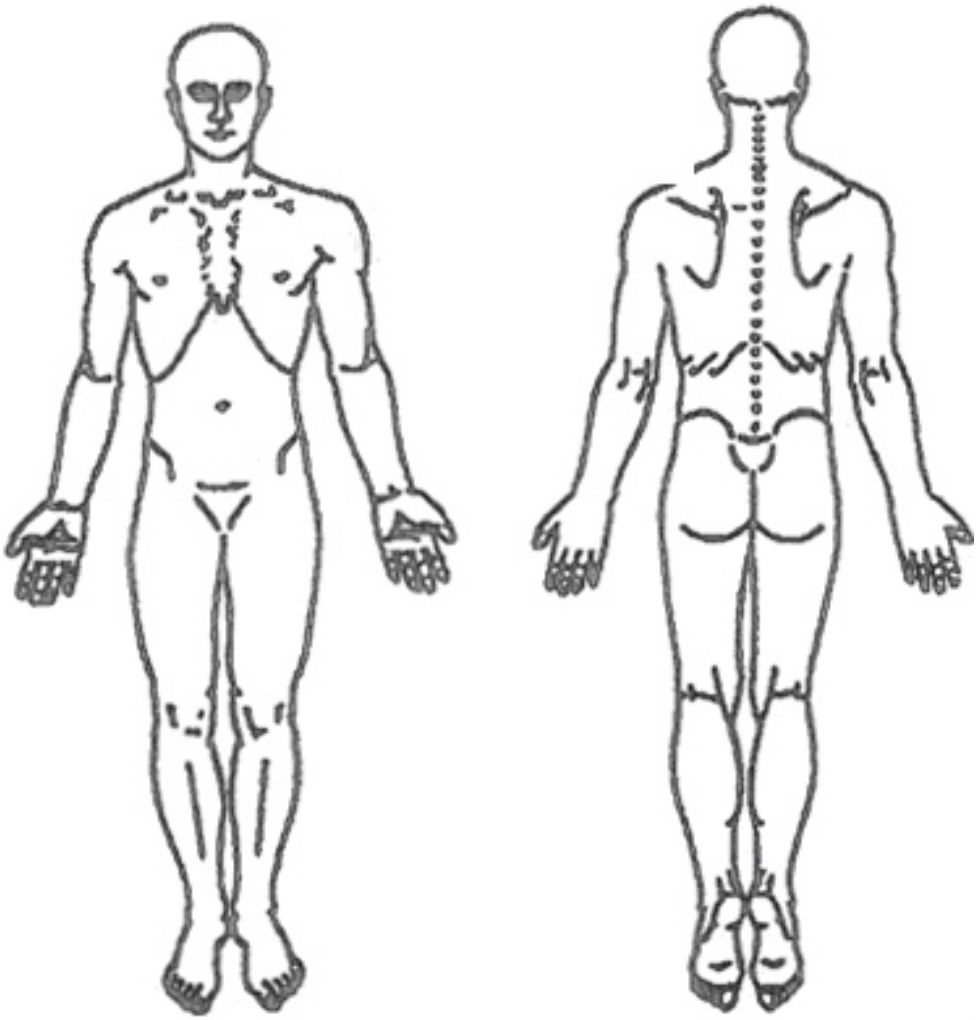
_____ _____

Therapist Signature Date

Pain and Symptom Status Report

Name:_____ Date:_____

Where is your pain?
Please mark on the drawings below, the areas where you feel your pain.



Chief Complaint and Pain Scale

My chief complaint is:_____

Please circle on the scale below to indicate your level of pain:

At Worst:	**No Pain**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Currently:	**No Pain**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
At Best:	**No Pain**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**

Active Solutions Physical Therapy
Notice of Health Information Practices

This notice describes how information about patients may be used and disclosed and how patients can get access to this information. Please review it carefully.

Introduction
Active Solutions Physical Therapy is committed to treating and using personal health information about all our patients responsibly. This Notice of health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes patient rights as they relate to personal health information. This applies to all personal health information as defined by federal regulations.

Understanding health Records/Information
Each time a patients visits Active Solutions Physical Therapy, a record of the visit is made. Typically, this record contains symptoms, examination and test results, diagnoses, treatment and plan for future care or treatment. This information often referred to as the health or medical records, can possibly serve as a:

-* Basis for planning care and treatment
-* Means of communication among the many health professionals who contribute to the care,
-* Legal document describing the care received,
-* Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in education health professionals,
- A source data for medical research,
- A source of information for public health officials charged with improving the health of this stated and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

*Most likely uses of personal health information at Active Solutions Physical Therapy.

Understanding what is your record and how your health information is used helps you to; ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:
Although your health record is the physical property of Active Solutions Physical Therapy, the information belongs to you. You have the right to:
-Obtain a paper copy of this notice of information practices upon request
- Inspect and copy the health record (A reasonable fee may be required),
- Request an amendment of the health record
- Obtain a list of disclosures of the health information
- Request a restriction on certain uses and disclosures of your information and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our responsibilities
Active Solutions Physical Therapy is required to:
- Maintain the privacy of the health information,
- Provide patients with this notice as to your legal duties and privacy practices with respect to information that we collect and maintain,
- Abide by the terms of this notice,
- Notify the patients if we are unable to agree to a requested restriction.

We reserve the right to change our practices and to make the new provisions effective for al the protected information we maintain. Should our information practice change, we will provide the updated policy at the time of a future visit.

Initials: _____ Date: _____/_____/_____