



## INITIAL PATIENT QUESTIONNAIRE FORM

*IT IS IMPORTANT TO FILL THIS FORM OUT COMPLETELY*

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

1. Sex: ☐ Male ☐ Female ☐ Right Handed ☐ Left Handed Occupation: \_\_\_\_\_

2. Chief Complaint (where is your pain?): \_\_\_\_\_

3. Onset Date (Date of Injury): \_\_\_\_\_

4. Type of Injury/Condition: ☐ Gradual Onset ☐ Work Comp. ☐ Auto ☐ Surgery ☐ Sports ☐ Other

5. Specifically describe your injury/condition: \_\_\_\_\_

6. Surgery Date: \_\_\_\_\_ Type of Surgery: \_\_\_\_\_

\*Are you currently seeing a home health physical therapist? ☐ Yes, last treatment date: \_\_\_\_\_ ☐ No

7. Diagnostic testing related to this injury/condition: ☐ X-Ray results: \_\_\_\_\_ ☐ MRI Results: \_\_\_\_\_

8. Treatments related to your injury/condition: \_\_\_\_\_

9. Circle the number that best represents your level of pain

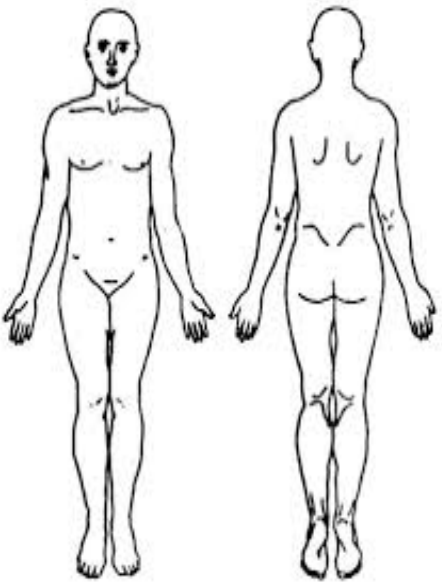
NO PAIN   1   2   3   4   5   6   7   8   9   10   WORST PAIN

10. What lessens your pain? \_\_\_\_\_

11. What activities are you having difficulty with as a result of your injury/condition?

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_

	<p style="text-align: center;"><b>Where is the pain?</b></p> <p>Place symbols of your pain description on the body diagram on the left. This is to help us understand more about your symptoms. Please create your own symbols to describe your pain.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 50%;">Pain Symbol</th> <th style="width: 50%;">Description</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">X</td> <td style="text-align: center;">Sharp</td> </tr> <tr> <td style="text-align: center;">O</td> <td style="text-align: center;">Numbness</td> </tr> <tr> <td style="text-align: center;">A</td> <td style="text-align: center;">Achy</td> </tr> <tr> <td style="text-align: center;">S</td> <td style="text-align: center;">Stiffness</td> </tr> </tbody> </table>	Pain Symbol	Description	X	Sharp	O	Numbness	A	Achy	S	Stiffness
Pain Symbol	Description										
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12. (a) Have you had two or more falls in the past year?

☐ Yes ☐ No

(b) Have you had any falls with injury in the past year?

☐ Yes ☐ No

(c.) Were any falls as a consequence of sudden onset paralysis, Epileptic seizure, or overwhelming external force?

☐ Yes ☐ No

## PATIENT MEDICAL HISTORY

Condition	Yes ✓	Condition	Yes ✓
Anxiety/Depression		Chest pain( <i>angina</i> )/ Prior Heart Attacks	
Arthritis ( <i>Rheumatoid or Osteoarthritis</i> )		Pacemaker	
Asthma		Visual Impairment	
Chronic Pulmonary Disease, Respiratory Distress Emphysema		Neurological Disease ( <i>Multiple Sclerosis, Parkinson's, etc.</i> )	
Congestive Heart Failure/Heart Disease		Osteoporosis	
Cancer		Peripheral Vascular Disease	
Back pain ( <i>degeneration, stenosis, severe chronic back pain</i> )		Upper Gastrointestinal Disease ( <i>ulcer, hernia, or reflux</i> )	
Diabetes ( <i>Types I or II</i> )		Dementia	
Bipolar		Stroke or Mini Stroke (TIA)	
Hearing Impairment		Pregnant	

## CURRENT MEDICATIONS

*(If you have a list, please feel free to ask our front office staff to make a copy for you)*

Name of Medication	Dosage	Frequency	Route of Administration

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

## PATIENT DEMOGRAPHICS

REFERRING PHYSICIAN: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **(Required for billing of VA patients)**

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**\*\*If you are a dependent or spouse on your insurance account, please provide the following information to ensure proper billing:**

Spouse/Parent Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **(Required for billing of VA patients)**

Who is responsible for the account? \_\_\_\_\_ Phone #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

*I verify the above information is correct and will be used only by the Physical Therapist and his staff to ensure my health and safety.*     **Patient Initials** \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people have noticed or, the opposite - being so fidgety or restless.	0	1	2	3
9. Thoughts that you were be better off dead or of hurting yourself in some way	0	1	2	3

10. If you have checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all    
 ☐ Somewhat difficult    
 ☐ Very difficult    
 ☐ Extremely difficult  
 TOTAL: \_\_\_\_\_

Please answer the following questions if you are 65 years or older:			
1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	DID NOT ANSWER
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care or from being with people you wanted to be with?	YES	NO	DID NOT ANSWER
3. Have you been upset because someone talked to you in a way that made you feel ashamed or threatened?	YES	NO	DID NOT ANSWER
4. Has anyone tried to force you to sign papers or use your money against your will?	YES	NO	DID NOT ANSWER
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	DID NOT ANSWER
6. Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	DID NOT ANSWER

## **Treatment Consent, Statement of Financial Responsibility, Notice of Privacy Practices**

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, and assistants, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician/health care provider. *I acknowledge that no guarantees have been made to me about the results of treatment.* \_\_\_\_\_(initial)
2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I understand that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I agree to provide 24 hours notice of canceling/rescheduling appointments. I understand that in the event I cancel with less than 24 hours notice, or no-show my appointments 3 times, I may be removed from the schedule entirely. \_\_\_\_\_(initial)

**\*Workman's Compensation Attendance:** We appreciate your full cooperation in attending all scheduled therapy sessions. We are REQUIRED to inform your workers compensation adjuster and/or rehabilitation manager for all missed/canceled appointments. \_\_\_\_\_(initial)

3. **FINANCIAL POLICY:** A medical insurance policy is a contract between the patient and the insurance company. *Coverage depends upon a patient's insurance company and the specific plan chosen.* Peterson Physical Therapy is contracted with most insurance companies and agrees to submit claims directly to them. You may need a physician's referral for Physical Therapy in order to process these claims. Any questions you have regarding insurance coverage or benefits should be directed to your insurance plan. In order for us to submit claims to your insurance company, our office will need photocopies of your insurance card as well as a photo ID. I agree to provide updated insurance information as soon as it becomes available to me. \_\_\_\_\_(initial)

**\*Cost Share Policy:** All patient cost shares (copayments, coinsurances, and deductibles) are due at time of treatment. For patients with coinsurance and/or deductibles, a good faith payment is due at the time of treatment. A good faith payment is an estimate of what you will owe, based on verification of benefits.

When adjusted claims and EOBs are received from insurance, the patient will be billed for any balance that may remain. \_\_\_\_\_(initial)

I understand that a \$25 returned check fee will be applied to any failed payments due to insufficient funds.

I understand that failure to pay the balance on my account will result in Peterson Physical Therapy pursuing any collection means necessary.

**\*Workman's Compensation Policy:** Medical expenses resulting from a workplace injury will be submitted to the program on an open claim. However, if the claim is denied for any reason, the patient will be responsible for the total cost of care provided. \_\_\_\_\_(initial)

**\*Self-Pay Policy:** A self-pay rate is offered to those patients who do not have insurance, or do not wish to have their insurance billed. Payment will be due upon time of service. We will not bill the patient's insurance company for services provided under a self-pay arrangement. No forms will be produced now or in the future to submit claims for insurance billing. \_\_\_\_\_(initial)

**\*Rebilling Policy:** It is the patient's responsibility to provide correct and updated insurance information, *as soon as possible*. In the event that the incorrect billing information is provided, and claims are denied and returned, we will attempt to rebill the claims when we receive updated and correct insurance information. If rebilling is denied due to timely filing deadlines of the Payor, the patient will be fully responsible for treatment costs. \_\_\_\_\_(initial)

**\*Medicare Policy:** *The patient must provide secondary insurance information/ photocopies of insurance cards.* If Medicare is not set up to forward claims to the secondary insurance, the patient is responsible for ensuring their secondary insurance is billed separately. Failure to do so will result in billing the patient for any remaining balance. \_\_\_\_\_(initial)

**\*\*Medicare- Home Health:** I understand that *Outpatient Physical Therapy during Home Health Physical Therapy will not be covered by Medicare*, and I may be financially responsible for treatment. \_\_\_\_\_(initial)

I am not currently being treated by a Home Health Physical Therapist. I will notify Peterson Physical Therapy if I start Home Health Physical Therapy during my outpatient treatment. \_\_\_\_\_(initial)

4. **VERIFICATION OF BENEFITS:** As a courtesy to our patients, Peterson Physical Therapy will *attempt* to verify benefits. The information provided by insurance will be explained to the patient *the way we understand it*. Peterson Physical Therapy will file claims to insurance providers, and notify the patient of their financial responsibility. *The patient is aware that not all benefit information provided by insurance representatives is accurate, true, or correct.* It is the patient's ultimate responsibility to understand their own insurance plan benefits. *The patient understands that the verification of benefits and authorization process is done as a courtesy, and is not a guarantee of insurance payment. The patient is fully responsible for all charges not paid by their insurance company.* \_\_\_\_\_(initial)

5. **ASSIGNMENT OF BENEFITS:** I hereby assign to Peterson Physical Therapy, all of my rights and claims for reimbursement under my health insurance policy and such other insurance policies I may identify. \_\_\_\_\_(initial)  
I do hereby authorize Peterson Physical Therapy to release, to my insurance provider, all information necessary to secure the payment of said benefits. \_\_\_\_\_(initial)

6. **NOTICE OF PRIVACY PRACTICES (HIPAA):** We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to provide you notice of our privacy practices, our legal duties, and your personal rights concerning your health information. We are required to follow the privacy practices described in this notice. A copy of our Privacy Practices notice is displayed in our waiting room, additional copies will be provided to the patient upon request.  
I have been provided a copy of this notice for my reference. I understand my patient rights. \_\_\_\_\_(initial)

\_\_\_\_\_  
Printed Name of Patient or Legally Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Legally Responsible Party

\_\_\_\_\_  
Date