MR #:
Patient Name:

PERFORMANCE PRO PHYSICAL THERAPY PATIENT DATA SHEET

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

Mailing Address:

Phone Numbers: **OK To Call** **Best Time To Call**

Home:

Work:

Cell:

May we send you text messages for your appointment reminders to the number(s) listed above? ☐ Yes ☐ No

May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above? ☐ Yes ☐ No

By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email:

Preferred language: **Interpreter required?** ☐ Yes

Date of Injury: **Referring Physician:**

Injury Area: **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

State Where Accident Occured:

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: **Occupation:**

Address:

Phone:

Employer: **Occupation:**

Address:

Phone:

INSURANCE INFORMATION

Primary Insurance:

Policy Holder's Name: **Holder's Birth Date:**

Policy or Certificate #: **Group #:**

Policy Holder's Employer:

Secondary Insurance:

Policy Holder's Name: **Holder's Birth Date:**

Policy or Certificate #: **Group #:**

Policy Holder's Employer:

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other

Specify if other :

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

Name Relationship

Name Relationship

Signature of Patient

Date

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at: PERFORMANCE PRO PHYSICAL THERAPY

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:** _____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:** _____

LIABILITY

I know and agree that: PERFORMANCE PRO PHYSICAL THERAPY
is not responsible for loss or damage to personal valuables. **Initials:** _____

WAIVER AND RELEASE

I hereby release, discharge and acquit: PERFORMANCE PRO PHYSICAL THERAPY
its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Initials:** _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: PERFORMANCE PRO PHYSICAL THERAPY
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. **Initials:** _____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. **Initials:** _____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:** _____
I acknowledge receipt of the Statement of Patient Rights. **Initials:** _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ **Witness Signature** _____ **Date** _____

PerformancePro Sports Medicine & Rehabilitation
Patient Subjective Medical History Form
Entire Form – 2 Pages

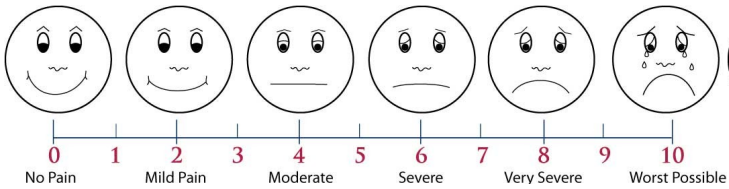
Patient Name:_____ **Age:**_____ **DOB:**_____
Referring Physician:_____ **Next Appt Date:**_____
Other Physicians(s) Currently Seeing:_____
Restrictions from your physician? □ Yes □ No Describe:_____
_____
Are you currently receiving home health or reside in a nursing home? □ Yes □ No
Date of Onset of Symptoms:_____ Work related:□ Yes □ No Car Crash: □ Yes □ No
Injury Date:_____ **Surgery Date(s):**_____ How did the injury/symptoms begin:
_____

Check any previous treatments received for THIS condition:
□ Physical Therapy □ Ocupational Therapy □ Massage □ Injections □ Chiropractic □ Hospital □ Home Health
When & how many / long for each treatment circled:_____
_____

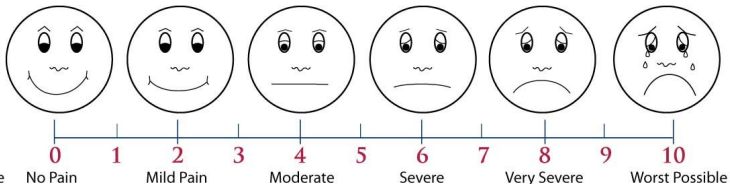
Circle/indicate with a "C" your current, and a "P" your prior level of function/ability to perform your normal home & work activities:

"0"=Unable 0 1 2 3 4 5 6 7 8 9 10 "10"=Fully Able

Rate your pain level on the following scale **WITHOUT** medication:



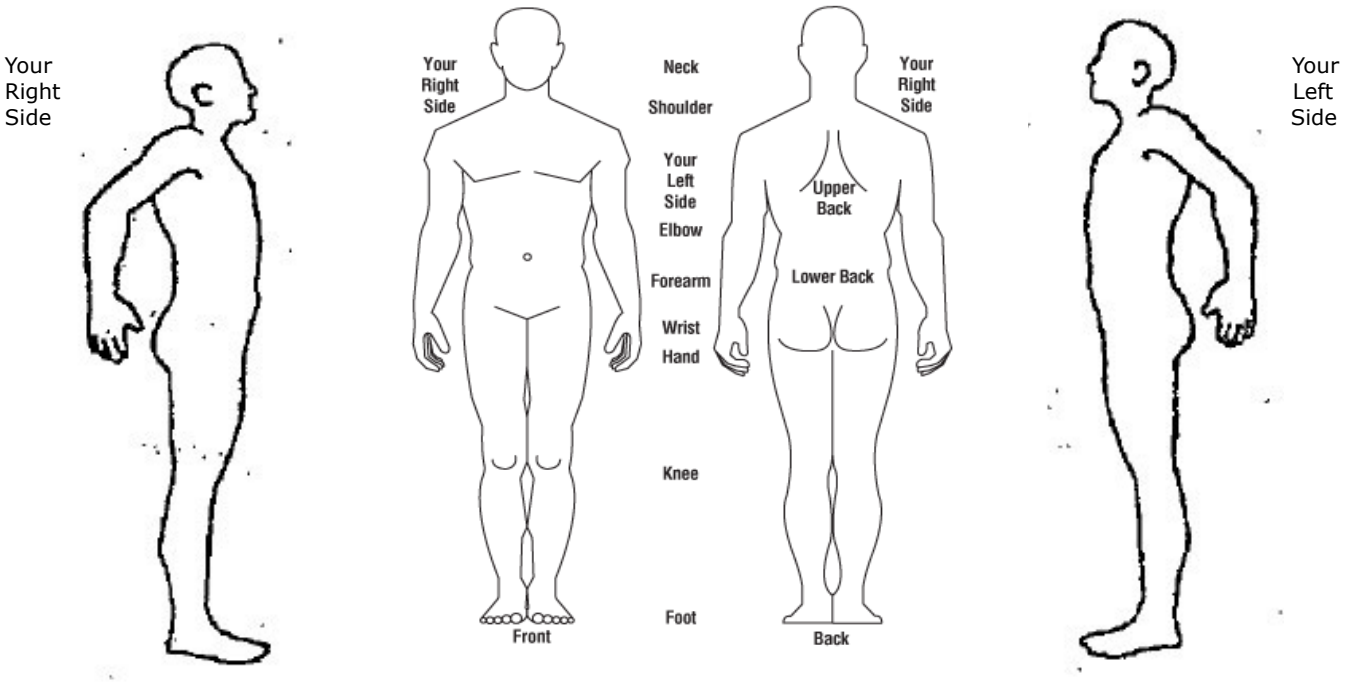
Rate your pain level on the following scale **WITH** medication:



Circle the best description(s) of your pain/symptoms:
constant, intermittent, sharp, dull, throb, ache, burning, numbness, tingling, pins/needles, tigthness/pulling, weakness, headache, bowel/bladder incontinence Other:_____

Does your pain affect your sleep? □ Yes □ No Describe:_____
What **increases** your pain?_____
What **decreases** your pain?_____
How do you feel in the:
Morning: better or worse **Afternoon:** better or worse **Evening:** better or worse

Share where your **worst** pain is on the diagram by writing "P1", write "P2" for additional areas & any areas of numbness write "N":



Patient Name: _____

Diagnostic Testing:
Have you had any tests? □ X-ray □ CT Scan □ MRI □ Myelogram □ EMG □ Culture
Other:_____ Results: _____
What is / was your occupation? _____ Employer: _____
Are you currently working: Full Time Part Time Light Duty Not at all Retired Other:_____
Physical lifting requirements to perform your job:
□ Sedentary □ Light □ Moderate □ Heavy □ Very Heavy - Up to _____pounds

Work/daily activities require prolonged:	Sitting	Standing	Bending	Lifting	Driving	Pushing	Pulling
# Hrs required / involved in per day							

List all specific activities you have difficulty with due to your condition:

List any regular exercise or recreational activities you participate in:

What GOALS do you hope to accomplish with physical therapy:

DO YOU NOW, OR HAVE YOU EVER, HAD ANY OF THE FOLLOWING CONDITIONS?
(check all that apply)

□ ANEMIA
□ ARTHRITIS
□ CANCER
□ HEART PROBLEMS
□ HEPATITIS/HIV
□ HIGH BLOOD PRESSURE: Controlled □Yes □No
□ RECENT WEIGHT LOSS
□ HISTORY OF FALLS
□ PACEMAKER
□ MRSA (Methicillin Resistant Staphylococcus Aureus)
□ DIABETES: Controlled □Yes □No
□ SEIZURES: Controlled □Yes □No
□ DIZZINESS/FAINTING
□ FRACTURES
□ THYROID PROBLEMS
□ LOW BLOOD PRESSURE
□ CURRENTLY PREGNANT
□ VISUAL IMPAIRMENT
□ HEADACHES/MIGRAINES
□ METAL IMPLANTS
□ RESPIRATORY PROBLEMS
□ ASTHMA: Controlled □Yes □No
□ COPD: Controlled □Yes □No
□ HOLTER MONITOR: wearing?
□ KIDNEY PROBLEMS
□ OSTEOPOROSIS
□ LATEX ALLERGY
□ NIGHT SWEATS
□ DEPRESSION/ANXIETY
□ Other_____
□ Other_____

****If checked any above, explain:**

List or attach ALL surgeries and year / date:
1._____ 4._____
2._____ 5._____
3._____ 6._____

List or attach ALL current medications, dosages and vitamins:
1._____ 4._____
2._____ 5._____
3._____ 6._____

Drug allergies: □Yes □No If yes, describe: _____
Do you smoke: □Yes □No If yes, how much: _____ packs _____ day x _____ years
Do you drink alcohol: □Yes □No If yes, how much / often: _____
How did you learn of this clinic: □ Physician □ Friend □ Patient □ Social Media – platform: _____
□ Phone book □ Internet search engine: _____ □ Other: _____
Do you live with someone: □Yes □No who _____
Does your home have stairs: □Yes □No If yes, how many: _____

_____ _____ _____ _____
Patient Signature **Date** Therapist Signature Date

Attendance Policy

Thank you for choosing PerformancePro Sports Medicine & Rehabilitation as your therapy provider! Our staff is dedicated to providing you with the best quality therapy possible. Your participation in your care will be an integral part of your recovery.

Patient Discharges Due to Attendance:

We realize that conflicts arise, so please contact our office 24 hours before your appointment if you are unable to make your scheduled time. In exchange, we will do our best to work with your schedule change should the situation arise. **Three no show appointments and/or last minute (late) cancels (within 24hrs of your appointment) will result in you being discharged from therapy.** Only **YOU** are responsible for making sure that your missed / last minute cancelled appointments are rescheduled within a time frame that allows the clinic to offer your time slot to another patient. We will do all we can to make sure you stay on the schedule should a missed appointment occur. **If it has been 30 days since your last appointment and we have not had a response from you, you will be discharged from care.** You will need a new referral to resume treatment for any 30 day lapse of care.

No Shows & Fees:

I understand that if I have not arrived within the 1st 15 minutes of my scheduled appointment, AND have not spoken with clinic staff about this appointment within 24hrs **PRIOR** to the appointment, then I will be marked a no show & **will be charged a $30 fee that becomes my responsibility when I arrive for my next appointment.** This fee allows the clinic to recoup minimal lost income of not being able to fill my time slot with another patient.

Last Minute/Late Reschedules/Cancels & Fees:

I understand that if I do not speak with the clinic within 24 hrs of my scheduled appointment to reschedule or cancel an appointment, then that appointment is considered a last minute/late reschedule/cancel & **I will be charged a $30 fee that becomes my responsibility when I arrive for my next appointment.** Clinic staff will determine during a cancel/reschedule call received within 24hrs of the appointment whether the fee will be charged based upon the circumstances and patient cancel/reschedule history.

Workers Comp:

If you are covered under workers compensation insurance, it is **YOUR** responsibility to make sure to keep all of your appointments. Your claims adjuster tracks your appointments and is aware of late arrivals, cancels, reschedules and no shows. We are required to report this information as part of our contract with the insurance company. This documentation is considered part of your medical record.

TriWest / VA:

TriWest or a VA representative will call to verify that veterans are keeping their appointments, as the approval is for a specific number of visits within a certain date span, typically 120 days from the referral.

By signing below I acknowledge that I understand the attendance policy and agree to the no show / last minute cancel fee should it apply in my case. We look forward to being a valued part of your care and thank you again for choosing PerformancePro to aid in your healing!

_____	_____	_____
Patient Printed Name	Patient Signature	Date