Harbor Physical Therapy Patient Information Form

_____ _____ _____
Date Date of Birth Social Security Number

_____ Circle One: MALE FEMALE
First Name MI Last Name

_____
Street/P.O. Box Address City State ZIP

_____ _____ _____
Home Phone Number Cell Phone Number Email

APPOINTMENT REMINDER: ___Call Home# ___Call Cell# ___Text Cell# ___No Reminder

Employed / Unemployed / Retired _____
Employer / Occupation / Work Number

_____ _____
Emergency Contact Name, Number, Relationship Parent/Guardian (if under the age of 18)

For which body part are you being seen today? _____

Date of injury OR approximate date that symptoms started? _____

Surgery: _____**YES** _____**NO** Date of surgery/name of surgeon:_____

Which Physical Therapist are you seeing today? (Circle one) **Micah Emily Lauren Ben**

Which Physician referred you to Physical Therapy? _____

Who is your Primary Care Physician (PCP)? _____

Is this condition related to (circle one): Employment Auto Accident Other_____

How did you hear about our clinic? Doctor Friend Yellowpages Social Media Other:_____

INSURANCE INFORMATION:

_____ _____ _____
Primary Insurance Company Member ID Number Group Number

_____ _____ _____
Subscriber Name: (Self, Spouse, Parent, Other) Subscriber's social security # Subscriber's Date of Birth

_____ _____ _____
Secondary Insurance Company Member ID Number Group Number

_____ _____ _____
Subscriber Name: (Self, Spouse, Parent, Other) Subscriber's social security # Subscriber's Date of Birth

MEDICARE PATIENTS: If you are a Medicare patient, your PCP must certify physical therapy every 30 days after your initial visit. Your PCP may require that you see him/her for a re-evaluation to certify continued therapy. Initial: _____

HARBOR PHYSICAL THERAPY
CONDITIONS OF BILLING

Please read carefully and sign below where indicated.

1. **Assignment of insurance benefits**: I hereby assign all appropriate benefits and proceeds to Harbor Physical Therapy for application on my bill; I understand that any portions of my treatment not covered by insurance, including co-pays, are my responsibility.

2. **Financial Agreement**: I promise to pay for services rendered to me. Should this account be turned over to collections, I understand that I shall be responsible for any fees and/or collection expenses.

3. **Outside Services**: I understand that I may be billed separately for services such as equipment rental that are not included in the regular cost of therapy.

SIGNED:_____ DATE:_____

*****CANCELLATION & NO-SHOW POLICY*****

There is an automatic charge of $25 for missed appointments and cancellations made without 24-hrs notice.

You will not be charged for a missed or cancelled visit if you are able to reschedule your treatment during an existing opening on the same day.

SIGNED:_____ DATE:_____

FOR MEDICARE PATIENTS ONLY

I certify that information given by me in applying for payment under the appropriate laws of the social security act of HB 89-97 is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment of the unpaid charges of the therapists for whom Harbor Physical Therapy is authorized to bill in connection with its services. I understand that I am responsible for any health insurance deductibles and 20% of the remaining reasonable charges. I request that this authorization apply throughout the period of treatment.

SIGNED:_____ DATE:_____

Name_____

R5/99:kjb

Medical History Intake Form

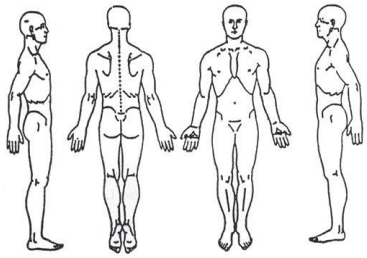
Below, please list all medications you are currently taking, what you are taking them to address, and how long you have been taking them

Medication	**Purpose:**	**Duration:**	**Dosage:**	**Frequency:**
Example: Tylenol	Severe Headaches	Past 5 days	250 mg	3xdaily

PLEASE CHECK IF YOU HAVE, OR HAVE HAD ANY OF THE FOLLOWING:

Yes/No		**Yes/No**		**Yes/No**	
☐	☐	Allergies	☐	☐	Depression	☐	☐	Lung Disease
☐	☐	Arthritis	☐	☐	Dizziness	☐	☐	Numbness/Tingling
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Osteoporosis
☐	☐	Attempted / Contemplated Suicide	☐	☐	Epilepsy	☐	☐	Pacemaker
			☐	☐	Head/Back Trauma	☐	☐	Possibly Pregnant
☐	☐	Bladder Trouble	☐	☐	Headache	☐	☐	Seizures
☐	☐	Broken Bones	☐	☐	Hearing Aids	☐	☐	Stroke
☐	☐	Cancer	☐	☐	Hearing Test	☐	☐	Tuberculosis
☐	☐	Car Accident	☐	☐	Heart Attack	☐	☐	Use of Tobacco
☐	☐	Chemical Reaction	☐	☐	Hepatitis	☐	☐	Vision Test
☐	☐	Chemotherapy	☐	☐	HIV / Aids	☐	☐	Wear Orthotics
☐	☐	Chest Pain	☐	☐	IV Antibiotics	☐	☐	Other_____
☐	☐	Cystic Fibrosis	☐	☐	Joint Pain			

On the diagram, please mark the location of your symptoms (pain, muscle tightness, tension, stiffness, swelling, spasm, etc)



Have you ever had an EMG, Angiograph, Ultrasound, MRI, CAT scan, or X-rays of your injured areas? If so, when and where? _____

Front office use only

Height:_____
Weight:_____
BMI:_____

Name_____

Physical Activity Readiness Questionnaire - PAR-Q (revised 2002)

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO		
☐	☐	1.	**Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
☐	☐	2.	**Do you feel pain in your chest when you do physical activity?**
☐	☐	3.	**In the past month, have you had chest pain when you were not doing physical activity?**
☐	☐	4.	**Do you lose your balance because of dizziness or do you ever lose consciousness?**
☐	☐	5.	**Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
☐	☐	6.	**Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart con- dition?**
☐	☐	7.	**Do you know of any other reason why you should not do physical activity?**

If you answered YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME _____

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN (for participants under the age of majority) _____ WITNESS _____

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

Supported by: Health Canada Santé Canada

continued on other side...