NEW PATIENT INFORMATION

Please print clearly

Name: (First)_____ (Last)_____ (M.I.)_____

Address: _____

City_____ State_____ Zip_____ Home Phone: _____

Cell Phone: _____ Text Messages: Y / N Email: _____

Social Security Number:_____ Date of Birth:_____ Age:_____Sex: M / F

Emergency Contact:_____Telephone:_____Relationship: _____

Referring/Primary Care Physician: _____Phone: _____

Social: Married / Single / Divorced / Separated / Widowed Have you been hospitalized in the past 60 days? Y / N

Employment: Full-Time / Part-Time / None / Retired / Student Employer: _____

Have you had ***physical therapy/ occupational therapy/chiropractic treatment*** this calendar YEAR? Y / N

If Yes, where? _____ Number of Visits: _____

How did you hear about us? *Returning Client Friend/Family Referring MD Self Referred Staff Social Media Website Internet Search Location/Signage Community Event Employer/Insurance Other:*_____

PAST MEDICAL HISTORY: ***Please check any condition that you currently have or have had in the past***

☐High Blood Pressure	☐Liver Disease	☐Arthritis: OA / RA	☐Cancer:_____
☐Lung Disease/COPD/Emphysema	☐Stroke	☐Fibromyalgia/Chronic Pain	☐Anemia
☐Heart Disease/Problems	☐Kidney Disease	☐Epilepsy/Seizures	☐Osteoporosis
☐PACEMAKER	☐Diabetes	☐Bowel/Bladder Dysfunction	☐Scoliosis
☐Asthma/Allergies	☐Angina	☐Recent Infection	☐Anxiety
☐Thyroid Problems:_____	☐Lyme Disease	☐Headache/Migraine	☐Lupus
☐Circulation/Bleeding Problems	☐Blood Clots	☐Chemical Dependency	☐Hernia
☐Multiple Sclerosis	☐Depression	☐Hepatitis	☐Tuberculosis
☐Sexually Transmitted Disease	☐Parkinson's	☐HIV	☐Other:_____

Currently, I am experiencing the following (check all that apply):

☐Unexplained Weight Loss/Gain	☐Difficulty Swallowing	☐Dizziness/ Lightheadedness
☐Increased Pain at Night	☐Headaches	☐ Changes in Bowel/Bladder Function
☐Fever / Chills / Sweats	☐Nausea / Vomiting	☐Depression
☐Changes in Appetite	☐Loss of vision/ Double vision	☐Shortness of Breath
☐Blood in Urine/ Stool	☐Numbness or Tingling	☐Excessive Fatigue
		☐Other: _____

During the past month, have you often been bothered by feeling down, depressed or hopeless? Y / N
During the past month, have you often been bothered by little interest or pleasure in doing things? Y / N

Are you allergic to latex? Y / N Do you live alone? Y / N Are you pregnant? Y / N
Do you smoke? Y / N Have you fallen over the past 12 months? Y / N If so, how many times? _____

Please list leisure activities/hobbies/exercise routine: _____

What activities comprise your typical day: Sitting / Standing / Walking / Lifting / Other:_____

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CURRENT CONDITION:

Describe the reason you are here? _____

_____

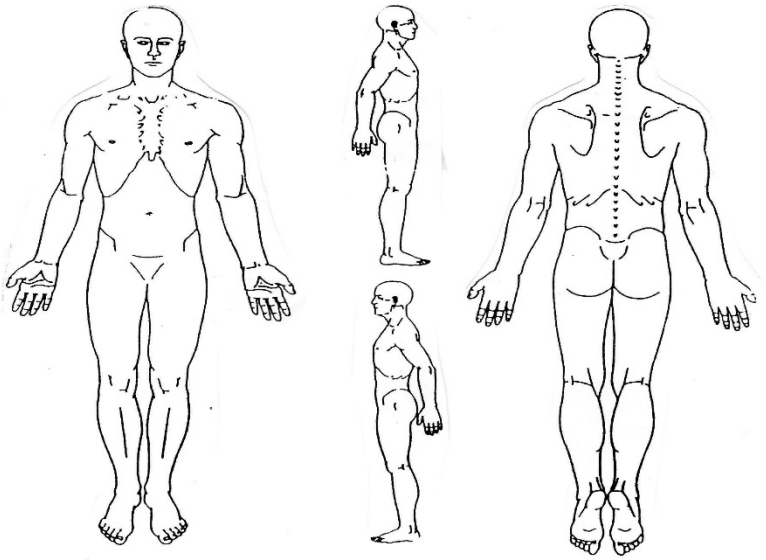
How did symptoms occur? ☐ Gradually ☐ Suddenly ☐ Injury: Home / Work / Auto / Sports / Other

When did symptoms start? _____ Symptoms are: ☐ Getting Better ☐ About Same ☐ Getting Worse

Have you ever had this problem before? Y / N Previous Treatments:_____

Have you had diagnostic imaging for this problem? X-ray / MRI / Ultrasound / CT Scan / EMG / Myelogram

Please mark symptom location/type on the diagrams below using these symbols:
(^^^ Numbness) (Pins & Needles) (xxxx Pain)***



Type of Pain: ☐ Ache ☐ Deep ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Stabbing ☐ Throbbing
Other:_____

Please rate your pain using 0-10 scale:
(0 is no pain at all, 10 is worst pain imaginable)

Current: 0 1 2 3 4 5 6 7 8 9 10

Least: 0 1 2 3 4 5 6 7 8 9 10

Worst: 0 1 2 3 4 5 6 7 8 9 10

What makes pain worse:_____

_____

What makes pain better:_____

_____

Please list ALL medications you are currently taking or use attached Medicare Medication Log:

_____

_____

_____

Please list prior surgeries including dates:

_____

_____

What are your physical therapy and/or fitness goals (write out or complete the sentence that applies to you)?

☐ Decrease pain with: _____

☐ Improve ability to:_____

☐ Leisure activities/Workout Routine:_____

The information above is HIPPA protected and is complete, true, and accurate to the best of my knowledge:

*Patient Signature:*_____ *Date:*_____

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Medication Log for Medicare Patients

Name: ______________________________ **Date:** ______________

Height: ________________ **Weight:** __________

Medicare requires that we collect data on the specifics of medications you use. Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	**Dosage**	**Frequency**	**Method of Administration**
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:
		As needed Daily: One / Two / Three Other:	Oral / Sublingual Topical / Injection Other:

COMPASS PHYSICAL THERAPY CONSENT TO TREATMENT

Name:_____**DOB:**_____

Notice of Privacy Practices: I acknowledge receipt of Compass Physical Therapy Privacy Policy. ***Initial:*** _____

Authorized Person(s): I authorize you to disclose information about my health, account, and/or treatment to:_____

Authorization to Release Information: I authorize the release of any medical or any other information to the Centers for Medicare and Medicaid Services (CMS), my insurance carrier(s), or other entities necessary to determine insurance benefits or benefits payable for related medical services and /or supplies provided to me by Compass Physical Therapy.

Financial Responsibility: I understand that insurance billing, including Workers Compensation Claims, is a service provided as a courtesy and that I am, at all times, financially responsible to Compass Physical Therapy. It is my responsibility to notify Compass Physical Therapy of any changes in my health care coverage. I am responsible for the entire bill or balance of the bill as determined by Compass Physical Therapy and/or my health care insurer if the submitted claims or any part of them are denied for payment. I request that payment of my services is made on my behalf to Compass Physical Therapy. I understand that Compass Physical Therapy may, during the course of treatment, recommend purchase of supply items. Supply items may or may not be covered under my insurance plan. I understand that it is my financial responsibility to pay for any item in full if it is not covered under my insurance plan. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and supply items. I also understand that Compass Physical Therapy collects for copayments at the time of service by cash, check, credit or debit card***. If using credit or debit card, payments are processed by Bluefin Payment Systems which maintains encrypted credit card data in order to apply payments for services rendered. Checks returned for insufficient fund will be subject to $25 processing fee.***

Below is an ***estimate*** of the amount you are responsible for based on information we obtain from your insurance carrier.

Co-pay: $_____ per visit Co-Insurance: _____% per visit Remaining Deductible: _____ ***Initials:***_____

Cancellation Policy: We require 24hr notice to cancel an appointment. The fee for cancellation without proper notification is $25 per visit. After three (3) missed appointments without proper notification, Compass Physical Therapy reserves the right to discharge the patient and/or recommend alternative therapy provider.

Consent to Treatment: I consent to and authorize Compass Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating and treating my condition.

Treatment of Minor: ***(if applicable)***
I authorize Compass Physical Therapy to treat _____ (Minor's name).
I authorize above named minor to attend visits unattended by parent/guardian and sign for his/her self at subsequent appointments: *Yes / No* _____ (parent/guardian signature).

This is to verify that I have read and agree with the above:

_____ _____

Patient or Responsible Party Date

Notice of Non-Discrimination Policy: Compass Physical Therapy does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment.