FAST TRACK Physical Therapy

Patient Information Form

Last Name_____ First Name_____ Middle_____
Address_____ City/State_____ Zip_____
Home Phone_____ Cell Phone_____ Work Phone_____
Date of Birth_____ SSN_____ Email Address_____
Employer_____ Marital Status_____ Facebook_____

Spouse's Name_____ Work Phone #_____ DOB_____
Nearest Friend/Relative not living with you: _____ Phone #_____
Emergency Contact Name_____Phone#_____

Physician_____ Phone #_____
Whom may we thank for referring you to us? _____
IF self-referral-how did you hear about us? _____

Insurance Company_____ Secondary Ins. Co._____
Policy #_____ Policy #_____
Group #_____ Policy #_____

Workman' Comp Claim? Yes____ No____ If Yes, date of injury_____
Insurance Co._____ Adjuster Name_____ Claim #_____
Phone #_____ Fax # _____ Adjuster Name_____ DOI_____

Auto Accident? Yes_____ No_____
Have you been seen for PT/OT or Chiropractor during the calendar year? Yes____ No____
Why did you choose Fast Track Therapy for your therapy services? _____

Who is the responsible party? / Legal guardian if a minor?_____
Date of Birth_____ Phone #_____ SSN_____
Address_____ Will you be paying today by: Cash___ Check___ CC___

Please provide proof of insurance coverage upon completion of this form.
Assignment and Authorization: I authorize the release of any medial information necessary to process insurance/Medicare claims on my behalf. I authorize payment of medical benefits directly to **Fast Track Physical Therapy** for services and supplies provided to me. A copy of this authorization shall be considered as valid as the original and valid for the duration of my care. I understand I am eligible for all charges incurred should my insurance not pay for these services (Except for Workers' Comp.)

Signature _____ Date _____

Patient Experience?
How was your experience when scheduling and first point of contact with our staff?

How long did it take you to get in? Less than 48 hrs.___ More than 48 hrs.___ More than 72 hrs.___ If more than 72 hrs., was that by your request? Yes___ No___ Do you know who you talked to?_____ Were you greeted upon arrival? Yes___ No___ Was the staff member friendly and did they answer all your questions? Yes___ No___ Please rate your initial experience with us. Exceeded my expectations___ Very Satisfied___ Satisfied___ Not Satisfied___

Name:_____ Date:_____ Referring Dr::_____ Next Follow up Apt?____

What is your main complaint or problem? _____

Date of onset:_____ How did it occur_____

Age:_____ **Height:**_____ **Weight**_____

Do you have a history of falls or have fallen in the past year? Yes___ No___ If yes did it result in injury? Yes___No___

Frequency of Symptoms: Constant____ Frequent____ Occasional____ Intermittent____

Pain level in the past 24 hours: No pain- 0 1 2 3 4 5 6 7 8 9 10- Extreme pain

Pain level in the past week: No pain- 0 1 2 3 4 5 6 7 8 9 10- Extreme pain

Pain at its best and worse: No pain- 0 1 2 3 4 5 6 7 8 9 10- Extreme pain

If you have pain, please circle those words which best describe it. *Decreased/Loss of function Loss of balance*
Sharp Dull Burning Throbbing Twinge Ache Numb Tingle Tight Pulling Weakness Stiffness

What medications are you taking for this problem? Please list the names of the medications: _____
Anti-inflammatory Pain killer Muscle relaxer Other _____

List of other medications you are currently taking: _____

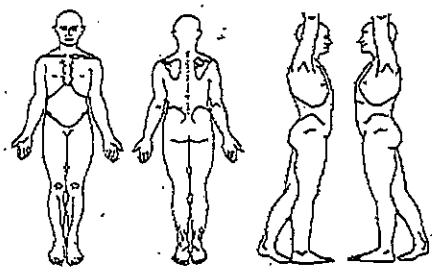
Date of surgery (if applicable) _____ Type of surgery _____

Please indicate painful areas by shading models.

X = pain

/ = tingling

O = numbmess



How do you feel in the Morning? *Better/worse* **Afternoon?** *Better/worse* **Evening?** *Better/worse* **Night?** *Better/worse*

What positions or activities make your pain better? _____

What positions or activities make your pain worse? _____

What tests/or treatment have you had for this problem? What were the findings? Pervious Therapy?

*X-ray MRI CT Scan Myelogram EMG Other*_____

What is your occupation? _____ Working: *Full time Light duty Not working*

Physical work requirements: *sedentary light moderate heavy very heavy*

Job requires prolonged: *sitting standing bending walking lifting squatting driving*

Do you have any of the following: *severe or frequent headaches dizziness bowel or bladder problems*
diabetes fibromyalgia stroke high blood pressure pacemaker Parkinson's pregnant

What are your goals you with to accomplish with physical therapy? _____
_____

FAST TRACK
Physical Therapy

Welcome to Our Office

We are pleased that you have chosen FastTrack Physical Therapy for your outpatient physical therapy- This information answers some of the most commonly asked questions about our services. Feel free to ask any additional questions. We look forward to working with you to attain your goals.

Payment for services: As a courtesy to you, we will obtain authorization and bill your insurance company. Please note: All insurance co-pays and co-ins are expected at the time services are rendered. It is the patient's responsibility to know their insurance plan and coverage.

Regarding Appointment: Appointment times range from 60-90 minutes. Our facility remains very busy, especially the early morning and late afternoon appointments. It is important for you to attend your appointments regularly. Inconsistency in receiving your therapy treatments can adversely affect your progress and outcome. If you need to cancel your appointment, please call 24 hours prior to your appointment to allow us to provide services to other patients. There will be a $25 cancelation fee for no shows or cancelations without 24-hour notice. Patients that consistently cancel or no-show appointments will be discharged and their doctor will be notified of the reason of discharged. Punctuality is appreciated so you can receive the maximum benefit from your appointment. Our staff does their best to be on time.

Works Compensation Patients Only: Please note that this office with notify your Workman's Compensation Insurance Adjuster of non-compliance after missed appointments.

Reposts to Physicians: We send a summary of your initial visit to your doctor. Please let us know 5-7 days in advance of future doctor appointments so we can send a letter informing them of your progress. Your written consent will be required to release medical records to anyone other than your physician and insurance company.

Hours of Operation: 7:00 am-7:00 pm Monday-Friday

Team Approach: Occasionally you may see a different Physical Therapist or Physical Therapist Assistant. This can offer new perspectives in treating your condition and enhance your progress. Your program and the services provided may change in response to your progress and needs. It is important that you do your home exercise program to improve your rate of progress. We look forward to working with you.

I will allow Fast Track Physical Therapy to use my testimonials. Yes___ No___

I will allow Fast Track Physical Therapy to use my photos for publication. Yes___ No___

I have received a copy of the Outpatient Guidelines and Privacy Practice HIPPA form, and I consent to treatment by the Fast Track Therapy staff.

Signature: _____ Parent or Guardian: _____

Date: _____