Atlantic Physical Therapy Center

www.ATLANTICPTCENTER.com

Referral Information

Past Patient: ☐ YES ☐ NO | Whom may we thank for referring you to us?

Patient Information

EMAIL:
(Providing email is consenting to receiving emails from Atlantic Physical Therapy Center)

Patient Name: (First, MI, Last, - Sr., Jr., etc) | SS #: ___ - ___ - ___

Address: | City | State: | Zip Code:

Please check one box as PRIMARY contact number.
☐ Home Phone: ( ) -
☐ Cell Phone: ( ) -
(Providing cell phone is consenting to receive texts. Text and data rates may apply.)

Date of Birth (mm-dd-yyyy) | Sex: ☐ M ☐ F | Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Date of Injury / Onset Date | Auto Related: ☐ Yes - State? _____ ☐ No | Work Related: ☐ Yes ☐ No | **Adjustor Name & Telephone #:** Claim # _____

If Workers Comp, was accident with present Employer? ☐ Yes ☐ No

If No, who was employer? _____

Occupation: _____

If Auto Accident, Date of Accident:___ / ___/ __
Type of Accident: Driver / Passenger / Pedestrian / Job / Fall / Other

Do you have Medicare Insurance Coverage? ☐ **No** ☐ **Yes** Are you receiving Home Health Services? ☐ No ☐ Yes

Primary Insurance Information (If you are the policy holder – you may **skip** this section)

Name of Insurance Company: | Policy or Claim #: | Group # / Policy Holders Employer:

Policy Holder Name: | Date of Birth: | Social Security #

Policy Holder Address: | Policy Holders Phone #: | **Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Information (Backup if Auto is Primary)

Name of Insurance Company: | Policy or Claim #: | Group # / Policy Holders Employer:

Policy Holder Name: | Date of Birth: | Social Security #

Policy Holder Address: | Policy Holders Phone #: | **Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Employer Information

Employer Name: | Employer Phone #: | Employment Status: ☐ None ☐ FT ☐ PT ☐ Self-Emp. ☐ Retired ☐ Student

Address: | City | State: | Zip Code:

Emergency Contact Information

Contact Name: | Phone # | Relationship to Patient: ☐ Parent ☐ Spouse ☐ Sibling ☐ Child ☐ Other

Financial Policy

As the patient, you are responsible for knowing the policies and procedures of your insurance plan, including pre-certification requirements, limitations, maximum benefits, co-payments, etc. As a courtesy, we will submit all primary and secondary insurance billing. Any remaining balance such as co-insurance, deductible, etc. is your responsibility. If you have any questions please speak to a member of our office staff.

I _____authorize Atlantic Physical Therapy Center to treat me as per my doctor's prescription and to release to my insurance company/Employer any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims for benefits.

Signature: _____ Date: _____

Atlantic Physical Therapy Center Pain Profile

1. What activities increase your problem: _____

2. What activities decrease your problem: _____

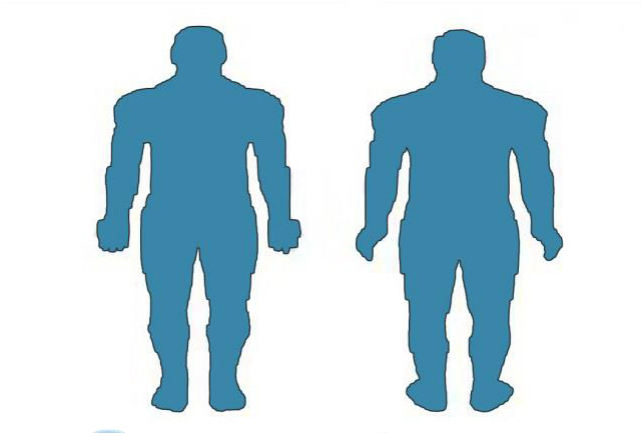
3. Are you presently working? Yes ☐ No ☐ Occupation: _____

4. What do you hope to accomplish with PT? _____

5. **REQUIRED BY INSURANCE – Please provide us your Height:_____ Weight:_____**

Please shade/circle in the areas that correspond to your pain or numbness

FRONT **BACK**



Please Rate Pain

(0 = none; 10 = worst)

0
1
2
3
4
5
6
7
8
9
10

Injury Information

Work Related Injury Athletic Injury Motor Vehicle Accident Other: _____

Date of Injury / Surgery _____ Date of next doctor's visit _____

Have you ever had these symptoms before? _____

Please check any of the following that apply to you:

_____ Diabetes
_____ Chest pain / Angina
_____ High Blood Pressure
_____ Heart Disease
_____ Heart Attack
_____ Heart Palpitations
_____ Pacemaker
_____ Headaches
_____ Kidney Problems
_____ Cancer
_____ Bowel / Bladder Abnormalities
_____ Liver / Gall Bladder Abnormalities
_____ Asthma / Breathing Difficulties
_____ Smoking
_____ Osteopenia / Osteoporosis

_____ Allergies to Aspirin
_____ Allergies to Heat
_____ Allergies to Cold
_____ Other Allergies
_____ Hernia
_____ Seizures
_____ Metal Implants
_____ Dizziness / Fainting
_____ Recent Fractures
_____ Surgeries
_____ Skin Abnormalities
_____ Ringing in your Ears
_____ Nausea / Vomiting
_____ Special Diet Guidelines
_____ Rheumatoid Arthritis

Is there any information in your past medical history that we should know about?

_____

Are you presently taking any medication? _____ if yes, please list medications:

_____

Patient Signature _____ Date _____

PLEASE PROVIDE YOUR INSURANCE CARD TO COPY

ATLANTIC physical therapy center

OFFICIAL PHYSICAL THERAPY PROVIDER FOR THE LAKEWOOD BLUECLAWS

HIPAA PRIVACY POLICY NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Disclose health information in order to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment both directly and indirectly.

Disclose your health information in order to receive payment for the services we provide to you.

Disclose your health information for normal healthcare operations such as quality assessments and physician certifications.

PATIENT RIGHTS REGARDING MEDICAL INFORMATION

The Right to Inspect and Copy Your Information: You may review and copy your medical records and information.

The Right to Amend: You may ask that we amend your health information if you believe that your information is incomplete or incorrect.

The Right to Request Restrictions: You may request a restriction or limitation on how and what health information we disclose regarding you for treatment, payment of health operations or to your family or care-givers.

The Right to Confidential Communications: You may request that we communicate with you about medical matters in a certain format or a specific location.

The Right to Receive a Copy of this Notice: You may request and receive a copy of this notice (or our current notice) at any time by contacting this organization.

_____ _____

Print Patient Name | Relationship to Patient

_____ _____

Signature | Date

Injury

Date of most recent concussion ___/___/_____ **Have you ever had a previous concussion?** ❑ Y ❑ N

Please describe how your recent injury occurred

_____

The injury was a result of: ❑ a collision with another person/player ❑a collision with the ground

❑ a collision with a piece of equipment/object ❑non-contact trauma (whiplash)

Did you receive medical treatment after injury? ❑Y ❑ N **If so, what kind?** _____

On the day of your injury did you continue to play/work/participate in activity? ❑Y ❑ N

Were you wearing a helmet? ❑ Y ❑ N ❑NA

Have you continued to exercise since your injury? ❑ Y ❑ N

Did you lose consciousness? ❑ Y ❑N **How long?**_____

Have you lost memory of events which occurred BEFORE your injury? ❑ Y ❑N

Have you lost memory of events which occurred AFTER your injury? ❑Y ❑N

Have you had the following? ❑Brain MRI ❑Cervical Spine MRI ❑Brain CT ❑Skull or Cervical Spine X-ray

❑Neuropsychological Testing ❑ImPACT Test, when?_____

Are you still able to go to school/work? ❑Y ❑ N **How many hours?**_____ ❑ NA

Are classes/job more difficult for you? ❑Y ❑N ❑NA

Has your mood changed? ❑ Y ❑ N

Is it more difficult to spend time with friends and family? ❑ Y ❑ N

If you answered yes to any questions above please explain:_____

_____

How many hours of sleep are you currently getting? _____

Are you able to read without increase in symptoms? ❑ Y ❑ N

Does computer work aggravate symptoms? ❑Y ❑ N

Are you able to ride in a car? ❑ Y ❑N **Are you currently driving?** ❑Y ❑ N

During the past month have you been feeling down, depressed or hopeless? ❑Y ❑ N

During the last month have you been bothered by having little interest in doing things? ❑Y ❑ N

Learning/Environmental Factors:

Do you wear corrective lenses? ❑Y ❑ N **Date of last eye exam?** ___/___/_____

How do you learn best? (check all that apply) ❑visual ❑ auditory ❑demonstration ❑ written

Do you currently receive any special services/therapy/nursing? ❑Y ❑N **If yes, what?**_____

Are you able to perform all your self-care activities independently? ❑Y ❑ N

Are there any special cultural and/or religious concerns you would like to share or be considered during treatment?

_____

Have you ever been diagnosed with: ❑learning disability/dyslexia ❑ADD/ADHD ❑seizure disorder

❑Migraine headache ❑anxiety, depression, or any psychiatric condition

Please list current medications that you are taking? _____

Cerebral Concussion

Directions

The Post concussion Symptom Scale is essentially a "state" measure of perceived symptoms associated with concussion. That is, the athlete is asked to report his or her "current" experience of the symptoms. This allows tracking of symptoms over very short intervals, such as consecutive days or every few days. After reading each symptom, please circle the number that best describes the way the athlete has been feeling today. A rating of 0 means they have not experienced this symptom today. A rating of 6 means they have experienced severe problems with this symptom today.

Date tested							
Date of Last known concussion(s)							
SYMPTOM	**None**	**Mild**		**Moderate**		**Severe**	
Patient Type	0	1	2	3	4	5	6
Headaches	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Fatigue	0	1	2	3	4	5	6
Trouble Falling Asleep	0	1	2	3	4	5	6
Sleeping Longer	0	1	2	3	4	5	6
Sleeping Less	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Intolerance to Light	0	1	2	3	4	5	6
Intolerance to Noise	0	1	2	3	4	5	6
Irritation	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervousness	0	1	2	3	4	5	6
Stronger Emotions	0	1	2	3	4	5	6
Numbness or Tingling	0	1	2	3	4	5	6
Mentally Slower	0	1	2	3	4	5	6
Mentally Blurred	0	1	2	3	4	5	6
Difficulty Concentrating	0	1	2	3	4	5	6
Difficulty Remembering	0	1	2	3	4	5	6
Visual Problems	0	1	2	3	4	5	6
TOTAL SYMPTOM SCORE:							
GRAND TOTAL OF ALL SYMPTOMS:							

Step 1: Look up the Classification range.

Step 2: Consider that the athlete's true score falls in the range of +/- 8 points surrounding the obtained score.

DIZZINESS HANDICAP INVENTORY – Initial Visit

Name: _____ **Date:** _____

SECTION I

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

SECTION II - Part I

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes or "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1.	Does looking up increase your problem?	Yes[1]	No[2]	Sometimes[3]
E2.	Because of your problem, do you feel frustrated?	Yes[1]	No[2]	Sometimes[3]
F3.	Because of your problem, do you restrict your travel for business or recreation?	Yes[1]	No[2]	Sometimes[3]
P4.	Does walking down the aisle of a supermarket increase your problem?	Yes[1]	No[2]	Sometimes[3]
F5.	Because of your problem, do you have difficulty getting into or out of bed?	Yes[1]	No[2]	Sometimes[3]
F6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	Yes[1]	No[2]	Sometimes[3]
F7.	Because of your problem, do you have difficulty reading?	Yes[1]	No[2]	Sometimes[3]
P8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes[1]	No[2]	Sometimes[3]
E9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes[1]	No[2]	Sometimes[3]
E10.	Because of your problem, have you been embarrassed in front of others?	Yes[1]	No[2]	Sometimes[3]
P11.	Do quick movements of your head increase your problem?	Yes[1]	No[2]	Sometimes[3]
F12.	Because of your problem, do you avoid heights?	Yes[1]	No[2]	Sometimes[3]
P13.	Does turning over in bed increase your problem?	Yes[1]	No[2]	Sometimes[3]
F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes[1]	No[2]	Sometimes[3]
E15.	Because of your problem, are you afraid people might think you are intoxicated?	Yes[1]	No[2]	Sometimes[3]
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes[1]	No[2]	Sometimes[3]
P17.	Does walking down a sidewalk increase your problem?	Yes[1]	No[2]	Sometimes[3]
E18.	Because of your problem, is it difficult for you to concentrate?	Yes[1]	No[2]	Sometimes[3]
F19.	Because of your problem, is it difficult for you walk around the house in the dark?	Yes[1]	No[2]	Sometimes[3]
E20.	Because of your problem, are you afraid to stay home alone?	Yes[1]	No[2]	Sometimes[3]
E21.	Because of your problem, do you feel handicapped?	Yes[1]	No[2]	Sometimes[3]

E22.	Has your problem placed stress on your relationships with members of your family or friends?	Yes[1]	No[2]	Sometimes[3]
E23.	Because of your problem, are you depressed?	Yes[1]	No[2]	Sometimes[3]
F24.	Does your problem interfere with your job or household responsibilities?	Yes[1]	No[2]	Sometimes[3]
P25.	Does bending over increase your problem?	Yes[1]	No[2]	Sometimes[3]

SECTION II - Part II

Instructions: Put a check in the box that best describes you:

- ☐ **Negligible symptoms (0)**
- ☐ **Bothersome symptoms (1)**
- ☐ **Performs usual work duties but symptoms interfere with outside activities (2)**
- ☐ **Symptoms disrupt performance of both usual work duties and outside activities (3)**
- ☐ **Currently on medical leave or had to change jobs because of symptoms (4)**
- ☐ **Unable to work for over one year or established permanent disability with compensation payments (5)**

Therapist Use Only

Comorbidities:

☐Cancer
☐Diabetes
☐Heart Condition
☐High Blood Pressure
☐Multiple Treatment Areas
☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
☐Obesity
☐Surgery for this Problem
☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD9 Code: _____

PATIENT NAME: _____ **ID#:** _____ **DATE:** _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

NECK DISABILITY INDEX – INITIAL VISIT

1. Pain Intensity
(0) I have no pain at the moment.
(1) The pain is very mild at the moment.
(2) The pain is moderate at the moment.
(3) The pain is fairly severe at the moment.
(4) The pain is very severe at the moment.
(5) The pain is the worse imaginable at the moment.

2. Personal Care (washing, dressing, etc)
(0) I can look after myself normally without extra pain.
(1) I can look after myself normally but it causes extra pain.
(2) It is painful to look after myself and I am slow and careful.
(3) I need some help but manage most of my personal care.
(4) I need help every day in most aspects of self care.
(5) I cannot get dressed, wash with difficulty and stay in bed

3. Lifting
(0) I can lift heavy weights without extra pain.
(1) I can lift heavy weights but it gives me extra pain.
(2) Pain prevents me from lifting heavy weights off the floor but I can manage if they are on a table.
(3) Pain prevents me from lifting heavy weights but I can manage if they are conveniently placed.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

4. Headache
(0) I have no headaches at all.
(1) I have slight headaches which come infrequently.
(2) I have moderate headaches which come infrequently.
(3) I have moderate headaches which come frequently.
(4) I have severe headaches which come infrequently.
(5) I have headaches almost all the time.

5. Recreation
(0) I am able engage in all my recreational activities without pain.
(1) I am able to engage in my recreational activities with some pain.
(2) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
(3) I am able to engage in a few of my usual recreational activities with some neck pain.
(4) I can hardly do any recreational activities because of neck pain.
(5) I can't do any recreational activities at all.

6. Reading
(0) I can read as much as I want with no pain in my neck.
(1) I can read as much as I want with slight neck pain.
(2) I can read as much as I want with moderate neck pain.
(3) I can't read as much as I want because of moderate neck pain.
(4) I can hardly read at all because of severe neck pain.
(5) I cannot read at all because of neck pain.

7. Work
(0) I can do as much as I want to.
(1) I can only do my usual work but no more.
(2) I can do most of my usual work but no more.
(3) I cannot do my usual work.
(4) I can hardly do any usual work at all.
(5) I can't do any work at all.

8. Sleeping
(0) Pain does not prevent me from sleeping well.
(1) My sleep is slightly disturbed (<1 hr sleep loss).
(2) My sleep is mildly disturbed (1-2 hr sleep loss).
(3) My sleep is moderately disturbed (2-3 hr sleep loss).
(4) My sleep is greatly disturbed (3-4 hr sleep loss).
(5) My sleep is completely disturbed (5-7 hr sleep loss).

9. Concentration
(0) I can concentrate fully when I want with no difficulty.
(1) I can concentrate fully when I want with slight difficulty.
(2) I have a fair degree of difficulty concentrating when I want.
(3) I have a lot of difficulty concentrating when I want.
(4) I have great difficulty concentrating when I want.
(5) I cannot concentrate at all.

10. Driving
(0) I can drive my car without neck pain.
(1) I can drive my car as long as I want with slight neck pain.
(2) I can drive my car as long as I want with moderate neck pain.
(3) I can't drive my car as long as I want because of moderate pain.
(4) I can hardly drive my car at all because of severe neck pain.
(5) I can't drive my car at all.

Therapist Use Only			
Comorbidities:	☐Cancer	☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)	
	☐Diabetes	☐Obesity	
	☐Heart Condition	☐Surgery for this Problem	ICD9 Code:
	☐High Blood Pressure	☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)	
	☐Multiple Treatment Areas		