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: _____

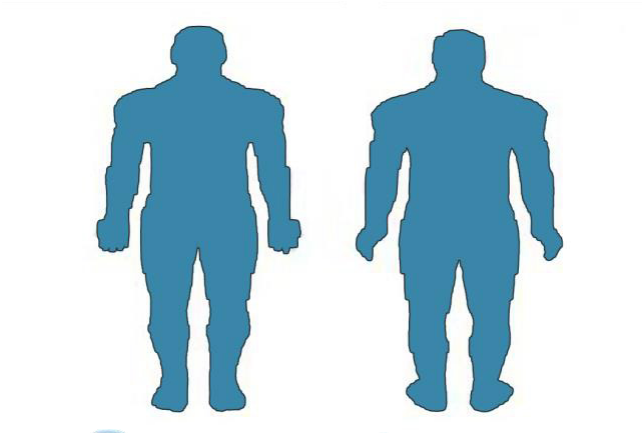
3. Are you presently working? Yes ☐ No ☐ Occupation: _____

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

QuickDASH - Initial Patient name:_____ Date:_____

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

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

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	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: