

Atlantic Physical Therapy Center

www.ATLANTICPTCENTER.com

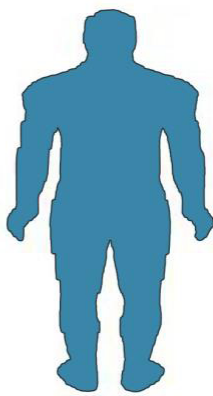
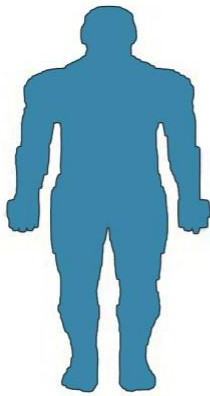
Referral Information					
Past Patient: <input type="checkbox"/> YES <input type="checkbox"/> NO		Whom may we thank for referring you to us?			
Patient Information		EMAIL: (Providing email is consenting to receiving emails from Atlantic Physical Therapy Center)			
Patient Name: (First, MI, Last, - Sr., Jr., etc)				SS #:	
Address:		City		State:	Zip Code:
Please check one box as PRIMARY contact number. <input type="checkbox"/> Home Phone: () - <input type="checkbox"/> Cell Phone: () - <small>(Providing cell phone is consenting to receive texts. Text and data rates may apply.)</small>		Date of Birth (mm-dd-yyyy)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	
Date of Injury / Onset Date	Auto Related: <input type="checkbox"/> Yes - State? _____ <input type="checkbox"/> No	Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Adjustor Name & Telephone #: Claim # _____		
If Workers Comp, was accident with present Employer? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes Are you receiving Home Health Services? <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
Employer Information					
Employer Name:		Employer Phone #:		Employment Status: <input type="checkbox"/> None <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self-Emp. <input type="checkbox"/> Retired <input type="checkbox"/> Student	
Address:		City		State:	Zip Code:
Emergency Contact Information					
Contact Name:		Phone #		Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> 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:

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies to Aspirin |
| <input type="checkbox"/> Chest pain / Angina | <input type="checkbox"/> Allergies to Heat |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies to Cold |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other Allergies |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Metal Implants |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness / Fainting |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Recent Fractures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Bowel / Bladder Abnormalities | <input type="checkbox"/> Skin Abnormalities |
| <input type="checkbox"/> Liver / Gall Bladder Abnormalities | <input type="checkbox"/> Ringing in your Ears |
| <input type="checkbox"/> Asthma / Breathing Difficulties | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Special Diet Guidelines |
| <input type="checkbox"/> Osteopenia / Osteoporosis | <input type="checkbox"/> 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 _____



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

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:	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Multiple Treatment Areas	<input type="checkbox"/> Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) <input type="checkbox"/> Obesity <input type="checkbox"/> Surgery for this Problem <input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
		ICD9 Code: _____