

Atlantic Physical Therapy Center

www.ATLANTICPTCENTER.com

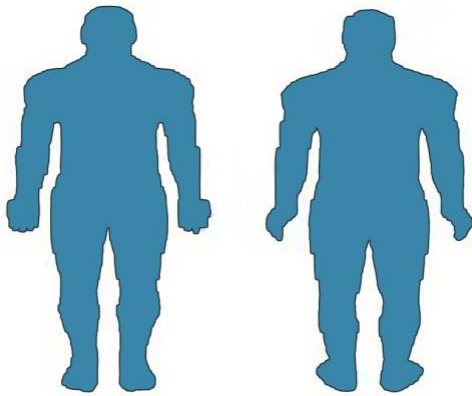
Referral Information					
Past Patient: <input type="checkbox"/> YES <input type="checkbox"/> NO		Whom may we thank for referring you to us?			
Patient Information					
EMAIL: (Providing email is consenting to receiving emails from Atlantic Physical Therapy Center)					
Patient Name: (First, MI, Last, - Sr., Jr., etc)				SS #: - -	
Address:			City		State: Zip Code:
Please check one box as PRIMARY contact number.		<input type="checkbox"/> Home Phone: () - -		Date of Birth (mm-dd-yyyy)	
<input type="checkbox"/> Cell Phone: () - - <small>(Providing cell phone is consenting to receive texts. Text and data rates may apply.)</small>		<input type="checkbox"/> Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Date of Injury / Onset Date		Auto Related: <input type="checkbox"/> Yes - State? _____ <input type="checkbox"/> No		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	
Adjustor Name & Telephone #:		Claim #			
If Workers Comp, was accident with present Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No				If Auto Accident, Date of Accident: ___ / ___ / ___	
If No, who was employer? _____				Type of Accident: Driver / Passenger / Pedestrian / Job / Fall / Other	
Occupation: _____					
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

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

MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT

1. Pain Intensity

- (0) I can tolerate the pain I have without having to use pain medication.
- (1) The pain is bad, but I can manage without having to take pain medication.
- (2) Pain medication provides me with complete relief from pain.
- (3) Pain medication provides me with moderate relief from pain.
- (4) Pain medication provides me with little relief from pain.
- (5) Pain medication has no effect on my pain.

2. Personal Care (washing, dressing, etc.)

- (0) I can take care of myself normally without causing increased pain.
- (1) I can take care of myself normally, but it increases my pain.
- (2) It is painful to take care of myself, and I am slow and careful.
- (3) I need help, but I am able to manage most of my personal care.
- (4) I need help every day in most aspects of my care.
- (5) I do not get dressed, wash with difficulty, and stay in bed.

3. Lifting

- (0) I can lift heavy weights without increased pain.
- (1) I can lift heavy weights, but it causes increased pain.
- (2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
- (3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- (4) I can lift only very light weights.
- (5) I cannot lift or carry anything at all.

4. Walking

- (0) Pain does not prevent me from walking any distance.
- (1) Pain prevents me from walking more than 1 mile.
- (2) Pain prevents me from walking more than 1/2 mile.
- (3) Pain prevents me from walking more than 1/4 mile.
- (4) I can only walk with crutches or a cane.
- (5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting

- (0) I can sit in any chair as long as I like.
- (1) I can only sit in my favorite chair as long as I like.
- (2) Pain prevents me from sitting more than 1 hour.
- (3) Pain prevents me from sitting more than 1/2 hour.
- (4) Pain prevents me from sitting more than 10 minutes.
- (5) Pain prevents me from sitting at all.

6. Standing

- (0) I can stand as long as I want without increased pain.
- (1) I can stand as long as I want but, it increases my pain.
- (2) Pain prevents me from standing more than 1 hour.
- (3) Pain prevents me from standing more than 1/2 hour.
- (4) Pain prevents me from standing more than 10 minutes.
- (5) Pain prevents me from standing at all.

7. Sleeping

- (0) Pain does not prevent me from sleeping well.
- (1) I can sleep well only by using pain medication.
- (2) Even when I take pain medication, I sleep less than 6 hours.
- (3) Even when I take pain medication, I sleep less than 4 hours.
- (4) Even when I take pain medication, I sleep less than 2 hour
- (5) Pain prevents me from sleeping at all.

8. Social Life

- (0) My social life is normal and does not increase my pain.
- (1) My social life is normal, but it increases my level of pain.
- (2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
- (3) Pain prevents me from going out very often.
- (4) Pain has restricted my social life to my home.
- (5) I have hardly any social life because of my pain.

9. Traveling

- (0) I can travel anywhere without increased pain.
- (1) I can travel anywhere, but it increases my pain.
- (2) My pain restricts my travel over 2 hours.
- (3) My pain restricts my travel over 1 hour.
- (4) My pain restricts my travel to short necessary journeys journeys under 1/2 hour.
- (5) My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment / Homemaking

- (0) My normal homemaking/job activities do not cause pain.
- (1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- (2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
- (3) Pain prevents me from doing anything but light duties.
- (4) Pain prevents me from doing even light duties.
- (5) Pain prevents me from performing any job or homemaking chores.

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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: _____