



### **Patient Case Information**

(IF PATIENT IS UNDER 18 YEARS OF AGE LEGAL GUARDIAN MUST SIGN ALL PAPERWORK)

Patient Name: (First) \_\_\_\_\_ (M.I.) \_\_\_\_ (Last) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Sex:  Male  Female Marital Status:  M  S  D  W

Primary Phone: \_\_\_\_\_ Secondary Phone : \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employment Status:  Student  Working  Retired  Homemaker  Unemployed

Email Address: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about Redmond Physical Therapy?  Doctor  Friend  Family  Google

Live  Yahoo  Yellow pages  Former Patient  Other \_\_\_\_\_

### **Current Injury / Accident Information:**

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Required by your Insurance)

Condition Related To:  Employment  Auto Accident  Other Injury \_\_\_\_\_

Attorney (if applicable) \_\_\_\_\_ Attorney's Telephone: \_\_\_\_\_

Injured Region(s) of Body: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Are you aware of your diagnosis and prognosis as explained by your doctor?  Yes  No

Please list any surgeries/procedures you have had for this injury: \_\_\_\_\_

Please list any current medications (prescribed and over the counter):  
\_\_\_\_\_  
\_\_\_\_\_

**Patient / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Functional Independence Questionnaire

**Please Read:** The purpose of this questionnaire is to allow us to understand how your current condition has affected your ability to perform everyday activities. **Please answer each section by circling the *one choice that best describes your condition right now.***

Section 1: Pain Intensity	
A	No pain.
B	The pain comes and goes and is mild.
C	The pain is constant but mild.
D	The pain comes and goes and is moderate.
E	The pain is constant and moderate.
F	The pain is severe but comes and goes.
G	The pain is constant and severe.

Section 2: Personal Care	
A	I can wash and dress without pain.
B	I do not have to change the way I wash or dress even though it causes some pain.
C	Washing and dressing increases the pain.
D	I have to change the way I wash and dress due to increased pain.
E	I am unable to wash and dress without help due to pain

Section 3: Lifting	
A	I can lift heavy weight without pain
B	I can lift heavy weight, but it causes increased pain.
C	Pain prevents me from lifting heavy weight off the floor.
D	I can only manage heavy weight if it is conveniently positioned (on a table).
E	I can only manage light to medium weight if it is conveniently positioned.
F	I can only lift very light weight, at the most.

Section 4: Walking	
A	Pain does not prevent me from walking any distance.
B	Pain prevents me from walking more than 1 mile.
C	Pain prevents me from walking more than ½ mile.
D	I can only walk while using an assistive device.
E	I can only walk to get around my house.
F	I am in bed most of the time and have to crawl to get around the house.

Section 5: Sitting	
A	I can sit in any chair as long as I like without pain.
B	I can only sit in a specific chair as long as I like.
C	Pain prevents me from sitting more than an hour.
D	Pain prevents me from sitting more than ½ hour.
E	Pain prevents me from sitting more than 10 minutes.
F	Pain prevents me from sitting at all.

Section 6: Standing	
A	I can stand as long as I want without pain.
B	I have some pain while standing, but it does not increase with time.
C	I can't stand for longer than 1 hour without increasing pain.
D	I can't stand for longer than ½ hour without increasing pain.
E	I can't stand for more than 10 minutes without increasing pain.
F	I avoid standing due to pain.

Section 7: Sleeping	
A	I can sleep a full night without waking due to pain.
B	I get pain in bed, but it does not prevent me from sleeping.
C	My normal night's sleep is reduced by less than 25%.
D	My normal night's sleep is reduced by less than 50%.
E	My normal night's sleep is reduced by less than 75%.
F	Pain prevents me from sleeping at all.

Section 8: Social Life	
A	My social life is normal and I have no pain performing desired activities.
B	My social life is normal, but activities cause increased pain.
C	Pain only has a significant effect on my more energetic activities (athletics, etc.)
D	Pain restricts my social life and I do not go out often
E	Pain has restricted my social life to my home.

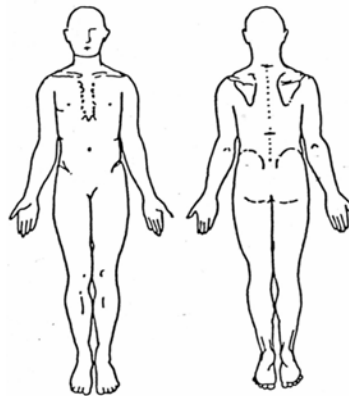
Section 9: Traveling	
A	I get no pain while traveling.
B	I get some pain while traveling, but it does not compel me to seek alternate forms of travel.
C	I get extra pain while traveling which compels me to seek alternate forms of travel.
D	Pain restricts/limits all forms of travel.
E	Pain prevents all forms of travel unless I can lay down.

Section 10: Changing Degree of Pain	
A	My pain is rapidly getting better.
B	My pain fluctuates, but overall is definitely getting better.
C	My pain seems to be getting better, but improving slowly.
D	My pain is neither getting better or worse.
E	My pain is gradually worsening.
F	My pain is rapidly worsening.

**Functional & Symptom Questionnaire continued**







Are your symptoms?  improving,  becoming worse, or  staying the same?

(Please Circle or Mark Painful or injured areas)



**B. Pictorial Pain Assessment Scale:**

Which one of the following best describes your pain? (Patient can reply by circling the words, numbers or pictures.

	Scale	
No pain	0	
	1	
Mild, annoying pain	2	
	3	
Nagging, uncomfortable, troublesome pain	4	
	5	
Distressing, miserable pain	6	
	7	
Intense, dreadful, horrible pain	8	
	9	
Worst possible, unbearable, excruciating pain	10	

**C. Visual analog scale:**

Mark the place on this line that best describes the severity of your pain.

No distress/no pain ..... Worst pain ever

**Patient / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Medical History**

- |                          |                       |                          |             |       |
|--------------------------|-----------------------|--------------------------|-------------|-------|
| <input type="checkbox"/> | Physical Therapy      | <input type="checkbox"/> | Acupuncture | _____ |
| <input type="checkbox"/> | Ergonomics Evaluation | <input type="checkbox"/> | CT Scan     | _____ |
| <input type="checkbox"/> | Chiropractic          | <input type="checkbox"/> | MRI         | _____ |
| <input type="checkbox"/> | Emergency Room Care   | <input type="checkbox"/> | Bone Scan   | _____ |
| <input type="checkbox"/> | Massage Therapy       | <input type="checkbox"/> | X-Rays      | _____ |

How Many Days a week do you perform Physical Activity? \_\_\_\_\_

Do you now have or have you ever had any of the following; Mark/Circle if necessary:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Asthma,                  | <input type="checkbox"/> Congestive Heart Failure  | <input type="checkbox"/> Back Injury/Surgery       |
| <input type="checkbox"/> Bronchitis, or           | <input type="checkbox"/> Hernia                    | <input type="checkbox"/> Osteoporosis              |
| <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Blood Clot/ Emboli        | <input type="checkbox"/> Knee Injury or Surgery    |
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Varicose Veins            | <input type="checkbox"/> Gout                      |
| <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Latex Sensitivities       | <input type="checkbox"/> Leg/ Ankle Injury/Surgery |
| <input type="checkbox"/> Lung Problems            | <input type="checkbox"/> Allergies                 | <input type="checkbox"/> Broken Bones/ Fractures   |
| <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> Allergies Tapes/Lotions   | <input type="checkbox"/> Pain with sneezing        |
| <input type="checkbox"/> Visual Difficulties      | <input type="checkbox"/> Thyroid Disease           | <input type="checkbox"/> Pregnant                  |
| <input type="checkbox"/> Hearing Difficulties     | <input type="checkbox"/> Goiter                    | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Coronary Heart Disease   | <input type="checkbox"/> Pins or metal implants    | <input type="checkbox"/> Tobacco                   |
| <input type="checkbox"/> Angina                   | <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Hypoglycemia              |
| <input type="checkbox"/> Pacemaker                | <input type="checkbox"/> Shoulder Injury/Surgery   | <input type="checkbox"/> Fibromyalgia              |
| <input type="checkbox"/> Dizziness or Fainting    | <input type="checkbox"/> Infectious Disease        | <input type="checkbox"/> Chronic Pain              |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Neck Injury/Surgery       | <input type="checkbox"/> Eating Disorders          |
| <input type="checkbox"/> Bowel / Bladder Problems | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Head Injuries             |
| <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Kidney Problems           | <input type="checkbox"/> Neurological Deficits     |
| <input type="checkbox"/> Heart Surgery            | <input type="checkbox"/> Liver Problems            | <input type="checkbox"/> Metal Implants            |
| <input type="checkbox"/> Weakness                 | <input type="checkbox"/> Joint Replacement         | <input type="checkbox"/> Other: _____              |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Cancer                    |  |
| <input type="checkbox"/> Seizures/Epilepsy        | <input type="checkbox"/> Elbow/Hand Injury/Surgery |  |
| <input type="checkbox"/> Weight Loss/ Fatigue     | <input type="checkbox"/> Arthritis                 |  |

Please list any other information that you believe would assist the therapist in your care:

\_\_\_\_\_

What are your rehabilitation expectations and goals while in this program?

\_\_\_\_\_

**Patient / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



***Consent for Treatment***

I agree to give my consent for *Redmond Physical Therapy Inc.* to furnish rehabilitation services considered necessary and proper in the treatment for my physical condition.

**Name of Patient:** \_\_\_\_\_  
(Please print complete name)

***Authorization for Disclosure of Medical Records***

I authorize *Redmond Physical Therapy Inc.* to release copies of the physical therapy record and billing statements to my insurance company for the purpose of billing for the services rendered.

***Information Privacy Statement***

*Redmond Physical Therapy Inc.* will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility, on our website, and have copies available for distribution upon request. The undersigned acknowledges receipt of this information.

I understand and agree to *Consent for Treatment, Authorization for Disclosure of Medical Records, and the Information Privacy Statement* above:

**Patient/ Guardian** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_



### **Financial Policy Statement**

Redmond Physical Therapy will bill your insurance carrier out of courtesy and as a convenience for you. However, you are ultimately responsible for payment for the services you receive. If your insurance company does not remit payment within 60 days, the balance will be due in full from you. If payment for services is made directly to you, you must promptly remit the payment to our clinic. If your insurance company remits only a percentage of the total balance due, you will be responsible for the remainder of the balance. **Co-Pays are always due at the time of service as described in your insurance policy.**

### **Billing Policy for Redmond Physical Therapy**

If we are billing your insurance company please contact your insurance company for information regarding your physical therapy benefits. As a courtesy our office staff will verify insurance coverage, but it is the patient's responsibility to confirm benefits with their insurance company prior to the first physical therapy appointment. (ask our front office with questions or consult our web page).

### **Balances owed to Redmond Physical Therapy**

- Balances unpaid after 60 days will accrue a 5% finance charge each billing cycle.
- Balances unpaid after 90 days must have payment arrangements with our billing office.
- Balances unpaid after 91 days will be turned over to our collection agency.

\*Checks returned with non-sufficient funds will be charged a \$25.00 fee.

### **Redmond Physical Therapy Cancellation/ No Show Policy**

- Redmond Physical Therapy appointments scheduled represent time set aside specifically for you as a patient. All cancellations must be made at least **24 hours** prior to the scheduled visit. Patients who cancel or no show on three separate occasions will be allowed to schedule additional appointments only at the discretion of the primary physical therapist.
- By law, all cancellations and no shows involving worker's compensation claims must be reported to your physician and your claims adjuster.
- **All Cancellations (less than 24 hour notice) and No-Call/ No-show appointments will be billed a charge of \$30.00 fee to your account. This fee is due before or at the time of your next physical therapy visit.**

I understand that my insurance company does not guarantee payment and I am financially responsible for all charges incurred with Redmond Physical Therapy. I understand and agree to the financial policy statement, billing policy statement, and cancellation policy.

Patient/ Guardian \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_