Patient Information / Subjective Information

Patient Name: ____________________
MailingAddress: ____________________
____
City/State/Zip: ____________________
Home Phone: __________ Cell Phone: __________
SSN: __________ Sex: ______
Date of Birth: __________ Age: ______
Email : ____________________

Spouse/Parent Name: ____________________
Mailing Address: ____________________
____
City/State/Zip: ____________________
Home Phone: ____________________
SSN: __________ Sex: ______
Date of Birth: __________ Age: ______
Spouse's Employer: ____________________
Job Title: __________ Job Phone: __________

Patient's Employer: ____________________
Job Title: __________ Job Phone: __________
Is your condition accident related?
Auto ☐ Work ☐ Other
How did the accident happen? ____________________
____
Date of Accident: ______ Date problem started: ______
# of work days missed: ____________________
Date of last Doctor's appointment: ____________________
Date of next Doctor's appointment: ____________________

In case of emergency call: ____________________
Emergency phone number: ____________________

***** FOR WORKER'S COMP PATIENTS ONLY *****
Worker's Comp Carrier: ____________________
Address: ____________________
City/State/Zip: ____________________
Adjuster: ____________________
Adjuster's phone: ____________________
Claim # : ____________________
Referring Physician: ____________________
Case Manager:

Primary Insurance Company: ____________________ **Secondary:** ____________________

What do you want to achieve with therapy? (Your goal) ____________________
What type of problem has brought you to therapy? ____________________
When did the problem begin? (date) ____________________
Have you ever had this problem before? ☐ Yes ☐ No If yes, when? ____________________
What type of treatment did you receive? ____________________
Have you received Physical Therapy this year? ______ If Yes, # of visits ______ Location: ______
Have you received Home Health this year? ______ If Yes, # of visits ______ Location: ______
List the Physicians you have seen for this for problem: ____________________
Have you had any injections for your injury/condition? Yes ☐ No ☐ When? __________ Did it help? Yes ☐ No ☐
Have you had any surgery? Yes ☐ No ☐ Explain: ____________________
Have you had any hospital stays related to this problem? ☐ Yes ☐ No Explain: ____________________
Are you ☐ employed ☐ Unemployed ☐ Retired ☐ Disabled?
If disabled, as of when? __________ Have you received a settlement? Yes ☐ No ☐
Has your doctor diagnosed you with Type One or Type Two Diabetes? Yes ☐ No ☐

Date: __________ Patient's Signature: ____________________

For Patients returning to HealthActions: I have reviewed all of the above information and made any appropriate changes
Date: __________ Patient's Signature: ____________________

Consent to Treat and Privacy Notification and Acknowledgement

Patient: ___________________________________ Date: ______________ DOB: ____________________
PLEASE PRINT

Consent to Treatment

Consent is hereby given for patient to receive treatment from HealthActions Physical Therapy and Wellness. I understand that risk may be associated with certain procedures, including but not limited to the risks associated with the use of the pool during aquatic therapy. __________
Initial

I certify that the billing information I have provided is correct. I authorize my insurance carrier to pay all benefits I may be due directly to HealthActions Physical Therapy and Wellness. Authorization is hereby given to release any information that may be necessary to process my insurance claims. ___________
Initial

Rights and Responsibilities

I can request a copy of my patient rights and responsibilities at any time. ______________
Initial

Release of Medical Information

I authorize the following persons to have access to my medical information and treatment.

Spouse: _____________
Family: _____________
Other: _____________
____
Initial

Privacy Notice

I can request a cop of the privacy notice for HealthActions

I agree that during the course of treatment my case may be discussed during weekly professional staff meetings for quality of care purposes. I agree to notifications and appointment reminders at my home address and phone number or this alternate phone number: _______________
____
Initial

I have read, initialed, and understand the content of this form.

____ ____
Patient Signature Date Witness Date

To be completed by HealthActions Physical Therapy and Wellness employee only if acknowledgement is refused.

After a good faith attempt to obtain this Acknowledgement, the patient or his/her representative refused or was unable to acknowledge receipt of our Privacy Notice for the following reason(s):

____ ________________________
Signature of Employee Date

24hr Cancellation/No show policy

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job.

- There is a $20 charge for a cancellation without proper notice. This charge will not be covered by insurance but will have to be paid by you personally. We require 24hrs notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full prescribed number of treatments that week whenever possible.
- In the event of a no call/no show to your scheduled appointment, this will result in a $50 charge and all future appointments removed from schedule. This charge must be paid in order to be placed back on schedule.
- For Worker's Compensation and Personal Injury patients' documentation of any missed appointments will be forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.
- You may need to see a therapist other than the one who normally treats you if you rearrange your appointment. All our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. You will return to your original therapist on the next regularly scheduled visit.

When you don't show as scheduled, three people are hurt: You, because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist, who now has a space in their schedule since the time was reserved for you personally; and another patient, who could have been scheduled for treatment if you had given proper notice.

Please note: Multiple cancellations (more than 3) may prevent us from being able to schedule you and may result in the need to treat you on a work-in basis.

______________________________ ______________________________
Patient Signature Date

______________________________ ______________________________
HealthActions Employee Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name:______________________________________ Date of Birth:__________________

I hereby authorize and request:

____(Releasor)
Name of Facility/Hospital

____
Address

____

To release to: **Health*Actions* Physical Therapy and Wellness** (Releasee)

(circle your location)

JACKSON	DOTHAN-EAST	THOMASVILLE	MONROEVILLE	TROY
P: 251-246-5761	P: 334-500-1150	P: 334-636-1461	P: 251-575-1933	P: 334-670-5435
F: 251-246-3779	F: 334-828-7125	F: 334-636-1463	F: 251-575-2807	F: 334-670-5234
DOTHAN-FLOWERS	**ORANGE BEACH**	**DAPHNE**	**ATMORE**	**ENTERPRISE**
P: 334-758-8288	P: 251-981-7778	P: 251-410-0620	P: 251-491-0200	P: 334-828-7591
F: 334-758-6988	F: 251-981-7773	F: 251-410-0621	F: 251-491-0201	F: 334-828-7298

A copy of the medical records on the above-named patient pertaining to:

________Outpatient care, date____

_______ Hospitalization, date(s) ________________________________

I acknowledge that data to be released may include material that is protected by Federal Law such as mental, drug and/or alcohol, HIV information. My signature below authorizes release to same. I understand this authorization is valid for 90 days and may be revoked by me at any time.

____ ______________
Signature (Patient) Date

____ ______________
Witness Date

Releasor, its agents and employees are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information.

HealthActions PHYSICAL THERAPY

Date:

Name: ____________________ DOB:__________ Age:_______ Height/Weight: ________

Please fill in the blanks and check any box that applies to you.

Coronary Artery Disease Risk Factors:

- Δ Male > 45 yrs of age
- Δ Female > 55 yrs of age
- Δ Diabetes Mellitus
- Δ Obesity
- Δ Sedentary lifestyle & job
- Δ Smoking
- Δ High Blood Pressure (>140/90 or on meds)
- Δ High cholesterol (>200mg/dl)
- Δ Family Hx of Coronary Artery Disease (father/brother had a heart attack by age 55, mother/sister had a heart attack by age 65)

Major Signs/Symptoms:

- ☐ Pain/discomfort in chest, neck, jaw or arms
- ☐ Shortness of breath at rest or mild exertion
- ☐ Dizziness, light-headed, or fainting
- ☐ Known heart murmur
- ☐ Ankle swelling
- ☐ Rapid or skipped heart beat
- ☐ UNUSUAL fatigue w/ USUAL activities
- ☐ Orthopnea/Nocturnal Dyspnea (difficulty breathing at night or when lying down)
- ☐ Orthopedic limitations (foot, back, neck, knee, hip, hand, wrist, shoulder problems, broken bones, limited range of motion in joints, arthritis, bursitis)
- ☐ Intermittent Claudication (Pain in calf with walking/activity)

Cardiopulmonary/Metabolic Disease:

- ☐ Heart Attack
- ☐ Diabetes Mellitus
- ☐ Hospitalized within past 6 mos.? ____________________
- ☐ Angioplasty
- ☐ Stable Angina
- ☐ Coronary Artery Bypass Grafting
- ☐ Congestive Heart Failure
- ☐ COPD (lung disease)
- ☐ Peripheral vascular disease
- ☐ Pacemaker

Other: Please check if currently or previously diagnosed with the following.

- ☐ Phlebitis or emboli ____________
- ☐ Rheumatic fever ____________
- ☐ Fibromyalgia ____________
- ☐ Low Blood Pressure ____________
- ☐ Trouble Sleeping ____________
- ☐ Migraine/Recurrent Headaches ____________
- ☐ Epilepsy or Seizures ____________
- ☐ Anemia ____________
- ☐ Cancer ____________
- ☐ Hernia ____________
- ☐ Tuberculosis ____________
- ☐ Allergies ____________
- ☐ Asthma ____________
- ☐ Emphysema ____________
- ☐ Bronchitis ____________
- ☐ Pneumonia ____________
- ☐ ↑ anxiety or depression ____________
- ☐ Emotional disorders ____________
- ☐ Ulcers ____________
- ☐ Stomach or intestinal problems ____________
- ☐ Hepatitis ____________
- ☐ eating disorder ____________
- ☐ Osteoporosis: ____________
- ☐ Other: ____________

MEDICATIONS WITH DOSAGE

(Include all Prescriptions/vitamins/herbs/over-the counter)

____

____

____

____

____

____

____

____

____

____

Have you had any surgery? ☐ Yes ☐ No

What type of surgery did you have? ____________________

____

Have you had any hospital stays? ☐ Yes ☐ No

When? ____________________

Signature: ____________________ **Date** ________

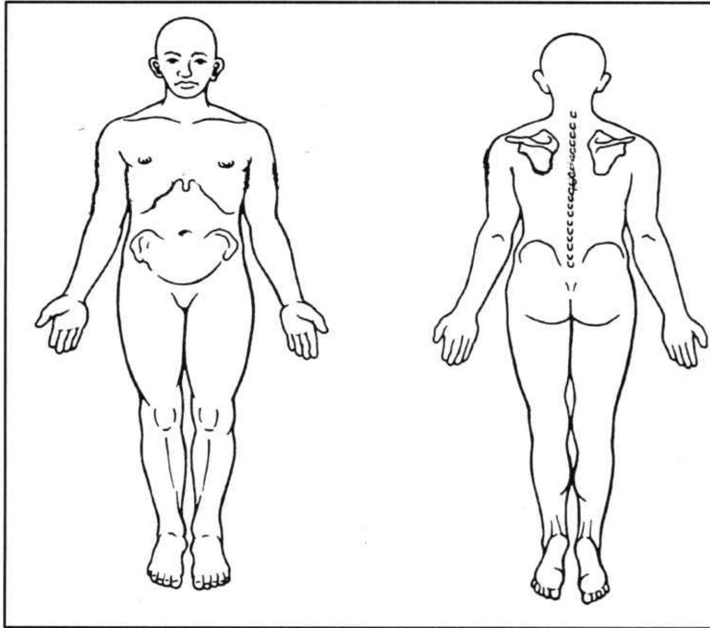
Signature of Parent/Guardian: ____________________ **(if under 19)** **Date**

Witness: ____________________ **Date**

PAIN INFORMATION

Name: ______________________________

Please mark the areas where you have pain, numbness, or tingling. ***P = Pain N = Numbness T = Tingling***



Pain level today. Select #:

1 2 3 4 5 6 7 8 9 10

(least pain -------------------- greatest pain)

What makes your pain less?

____

What makes your pain worse?

____

Is pain ☐ better or ☐ worse in the morning?

Is pain ☐ better or ☐ worse in the afternoon?

WHO is your employer? ______________________________

WHAT is your job title/responsibility? ______________________________

ARE you currently working? ☐ **Yes** ☐ **No** **how much** ☐ **Full Duty** ☐ **Restricted Duty**

Hours for typical work week? __________ **How many TOTAL workdays have you missed?** __________

What work duties/tasks have been stopped/limited by your injury/condition? ______________________________

How did you hear about us? (Please Select one)

- ◯ **1. Doctor Referral**
- ◯ **2. Website**
- ◯ **3. Online Search**
- ◯ **4. Radio**
- ◯ **5. TV**
- ◯ **6. Social Media (Facebook Twitter)**
- ◯ **7. Newspaper**
- ◯ **8. Mailer**
- ◯ **9. Free Screen Card**
- ◯ **10. Community Event**
- ◯ **11. Family/Friend**