Medical History Questionnaire

OVAL PHYSICAL THERAPY & SPORTS MEDICINE INC.

Patient Name _____ **Primary Language** _____

What is your occupation? _____

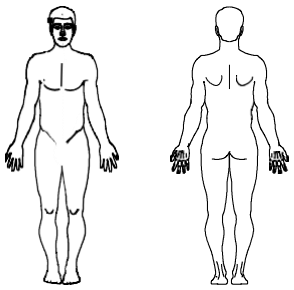
Describe Your Current Problem and How It Began _____

_____

Onset date/Surgery date Is _____

this? ☐ Work Related ☐ Auto Related ☐ N/A

Indicate below where you have pain or other symptoms



How often are your symptoms present?

☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms:

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Who have you seen for your current condition before today? No One

☐ Medical Doctor ☐ Massage Therapist ☐ Chiropractor ☐ Other _____
☐ Physical Therapist ☐ Acupuncturist ☐ Occupational Therapist ☐ Speech Therapist ☐ Athletic Trainer

What treatment did you receive and when? _____

_____

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No

Date(s) taken _____ **What areas were taken?** _____

Please check all of the following that apply to you:

□ Pain
□ Numbness/Tingling
□ Osteoarthritis
□ Rheumatoid Arthritis
□ Other Arthritic Conditions
□ Dizziness/Fainting
□ Recent Fever
□ Diabetes
□ Osteoporosis
□ High Blood Pressure
□ High Cholesterol
□ Circulation Problems
□ Stroke/CVA (Date)_____
□ Blood Clots
□ Asthma
□ Emphysema/Bronchitis
□ Tuberculosis
□ Multiple Sclerosis
□ Ehlers-Danlos Syndrome
□ Epilepsy
□ MRSA
□ Depression
□ Alcohol/Drug Dependence
□ Hepatitis
□ Stomach Ulcers

□ Cancer If Yes, describe what kind & treatment _____

□ Heart Problems If Yes, describe what kind & treatment _____

□ Kidney Problems If Yes, describe what kind & treatment _____

Medical History Questionnaire

OTHER CONDITIONS

Please check any of the below that you have experienced in the **last 12 months?**

☐ Easy Bruising
☐ Nausea/Vomiting
☐ Fatigue
☐ Weakness
☐ Fever/Chills/Sweats
☐ Stress at Home or Work
☐ Tremors
☐ Seizures
☐ Double Vision
☐ Loss of Vision
☐ Eye Redness
☐ Joint/Muscle Swelling
☐ Excessive Bleeding
☐ Difficulty Breathing
☐ Regular Cough
☐ Arm/Leg Swelling
☐ Heart Racing in your Chest
☐ Difficulty Swallowing
☐ Heartburn/Indigestion
☐ Constipation/Diarrhea
☐ Blood in Stool
☐ Blood in Urine
☐ Skin Rash
☐ Problems Sleeping
☐ Sexual Difficulties
☐ Urinary Incontinence
☐ Problems Urinating
☐ Fecal Incontinence

How much caffeinated coffee or other caffeinated beverages do you drink per day?_____

How many days per week do you drink alcohol?_____

If one drink equals one beer or one glass of wine, how much do you drink at an average sitting?_____

Are you now, or have you ever been, a smoker? ☐ Yes ☐ No

If Yes, how many packs of cigarettes do you smoke a day? _____

Have you ever taken an anticoagulant? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Have you ever taken steroid medications for any reason? ☐ Yes ☐ No

During the past month, have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

During the past month, have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ Yes ☐No

Are you currently pregnant or think you might be pregnant? Estimated Delivery Date?

Please list all surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization	
Date	**Reason for Surgery/Hospitalization**
1.	
2.	
3.	
4.	
5.	
6.	

Medical History Questionnaire

CURRENT MEDICATIONS

Please list **ALL** medications (INCLUDING prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional) supplements, injections, and/or skin patches) that you are **currently** taking. For each medication, please list the name, dosage, frequency, and route (by mouth, inhaler, intravenously, topically, etc.). You may attach a copy of your own list of medications if available. Only fill out the post-surgery medications if this section applies to you.

Current Medications:

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

****During the course of your Physical Therapy, if there are *any changes* (type or dosage) in your medications or supplements, it is important that you notify your therapist!****

I certify to the best of my knowledge, that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/ practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/ practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co- managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature: _____ **Date:** _____

Reviewed with Patient:_____ **Date:** _____

Evaluating Physical Therapist's Signature

OVAL PHYSICAL THERAPY & SPORTS MEDICINE INC.

CONSENT FOR CARE AGREEMENT

- I, the undersigned, do hereby agree and give my consent for Oval Physical Therapy & Sports Medicine INC to furnish medical care and treatment to,

_____, considered necessary and proper in diagnosing or treating his/her physical condition.
(Name of patient)

ASSIGNMENT OF BENEFITS AGREEMENT

- I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medigap, Medicaid, private insurance and third party payers to the Clinic.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient/Guardian _____ Date _____

Printed Name: _____

Relationship to Patient: _____

FINANCIAL POLICY STATEMENT

If you have health care benefits, the Clinic will submit a claim to your insurance company on your behalf and allow no less than 60 days for the insurance company to respond. However, you are required, and you agree, to pay at time of service any required co-payments and deductibles, as well as charges for services not covered by insurance, outstanding balances, and delinquent accounts. For your convenience, we accept cash, checks and credit/debit cards. By signing this document, you acknowledge that your insurance company may determine that the services provided are not covered under your insurance policy and agree that, if your insurance company determines that any services are not covered, you shall be responsible for, and shall pay, the cost of any such services. ***Initial*** _____

If you do not have health care benefits, you are required, and you agree, to pay at time of service, all charges as well as any outstanding balances and delinquent accounts. Patients that elect to be "Self Pay" are expected to pay at time of service.

We do not bill insurances for supplies, durable medical goods and equipment, and certain cash-based services (massage therapy, exercise classes, independent exercise, bike fitting, etc. You will be billed directly for these goods and/or services.

If you pay by check, and your check is dishonored or returned for any reason, we will expect payment in full plus a returned check fee of $50 within 30 days of the returned check. ***Initial***_____

I acknowledge that balances older than 90 days may be assessed an 18% annual percentage rate (APR) finance charge (1.50% per month).
If any debt is owed to the Clinic and is referred to an attorney or collection agency for collections, I agree to pay all attorney and collection fees in the amount of thirty-three percent (33%) of the total indebtedness, including all court costs and filing fees incurred by the Clinic. I understand and agree that should the Clinic be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1.50%) per month or eighteen percent (18%) per annum, beginning on the date of judgment. ***Initial*** _____

Under the assignment of benefits agreement above, if any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same amount to the Clinic. ***Initial***_____

☐ **Insurance**
We do our best to verify your plan benefits with your insurance company as a courtesy to you. However, benefits that we are quoted by your insurance company are not a guarantee of payment. Actual benefits are determined by your insurance company at the time the claim is processed. Co-pays will be collected at the time services are rendered. When payment from your insurance company is received, we will know then if we have to modify your co-pay. If you have a co-insurance, a deductible, or any other "Patient Responsibility" as determined by your insurance company, a bill will be sent to you with payment due upon receipt.

☐ **Worker's Compensation**
The above does not apply to those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for, and expected to pay, the total amount of charges for services rendered to you.

☐ **Cancellation/No Show Policy**
If you need to cancel an appointment, kindly provide at least 24 hours notice so that we may offer that time to another patient. Failure to provide 24 hours notice of need to cancel an appointment, or failing to appear for a scheduled appointment (No Show) will result in a $35 charge.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE FINANCIAL POLICY STATEMENT

Guarantor: _____ Date _____

Guarantor Printed Name: _____ Relationship to patient _____

OVAL PHYSICAL THERAPY & SPORTS MEDICINE INC.

You and your therapist have developed a treatment plan to maximize your progress in physical therapy in order to help you achieve your goals as efficiently as possible. In order to accomplish your treatment goals, adherence to that plan and your attendance is essential. We understand that normal life events may sometimes interfere with your treatment plan. If you need to cancel, please call us 24 hours before your appointment so that we can reschedule you as needed and offer your original appointment time to another patient that needs to be seen. There will be a $35 missed appointment fee for cancelling an appointment with less than 24 hours notice, or for missing an appointment without notice (No Show).

We appreciate your commitment to this process. If you miss two appointments without letting us know in advance (No Show) and without responding to our attempts to contact you, we will interpret that as your decision not to continue therapy. If this occurs, we reserve the right to cancel any future appointments you may already have on the schedule; and, to inform your physician of record.

If you need to cancel or change an appointment,
please contact the office you made your appointment.

I have received a copy of this statement and understand this policy.

Patient/Patient's Guardian Signature: _____

Dated: _____