# *Summit Strength Physical Therapy, LLC*

## *PATIENT PERSONAL INFORMATION*

Today's Date________________________

Name_______________________________________________Birthdate____________________

Home Address____________________________________________________________________
(Street) (City) (State) (Zip)

Home Phone #___________________Y / N_ Cell Phone #_______________________Y / N__
Message OK? Message OK?

Social Security #______________________________________________ (Male Female)

Email Address____________________________________________________________________

(Married Single Divorced Widowed Minor)

Employer________________________________Occupation______________________________

Employer Address_________________________________ Phone #________________Y / N
Message OK?

________________________________________________________________________________

**EMERGENCY CONTACT** (Relationship) (Phone)

***INJURY?*** *No* _____ *-or YES-date* ___________ *Auto* _____ *Work*_____ *Other* ______________

How did you hear about us? Prior Patient ___ Doctor ___ Friend (Name) _________ Other ______

**PERSON RESPONSIBLE FOR ACCOUNT** **CHECK BOX IF SAME AS ABOVE** ☐

Name__________________________Address__________________________________________

Relationship to client______________________Birthdate_________________________________

Social Security #_____________________________ Phone #_____________________________

Employer__________________ Address_______________________Phone #________________

Spouse's Name______________________ Birthdate__________ Social Security #_____________

Address______________________________________________ Phone #__________________

Spouse's
Employer__________________________Phone#________________________________________

Address__________________________________________________________________________

# *Summit Strength Physical Therapy, LLC*

## ***CONFIDENTIAL HEALTH HISTORY***

**Patient Name**:__________________________**Referring Physician**:______________________**Primary Care Physician**:______________________

Are you aware of your diagnosis?_______________________________________________________________________________________________

**Have you had any other orthopedic injuries or surgeries?** If yes explain___________________________________________________________

Have you had any prior physical or speech therapy visits this year? If yes how many visits?_________________

***At the present time, would you Rate your Overall General Health as: Excellent ____ Good ____ Fair ____ Poor_____***

**Please circle all conditions that you have or have had in the past**

**MUSCULOSKELTAL**
Osteoarthritis
Osteopenia
Osteoporosis
Rheumatoid Arthritis
Lupus/SLE
Fibromyalgia
Headaches/Migraines
Bulging Disk
Leg Cramps/Restless Leg
Jaw Pain/TMJ
History of Falling
Use of Cane/Walker
Gout
Other:________________

**CIRCULATION/RESPIRATORY**
Heart Disease
Heart Surgery
Heart Arrhythmia
Pacemaker
Myocardial Infarction
Angina/Chest Pain
Mitral Valve Prolapse
Aneurysm
High Cholesterol-On Statin Meds
Anemia
Blood Clots/Phlebitis
Asthma/SOB
COPD
Low Blood Pressure
High Blood Pressure – Controlled Y N
Meds for BP:______________________

**ENDOCRINE/DIGESTION**
Diabetes
Low Blood Sugar
Kidney Dysfunction
Irritable Bowel Syndrome
Crohn's Disease
Bladder Dysfunction
Liver Dysfunction
Thyroid Dysfunction
Hernia
Unexplained Weight Loss/Gain
Other:_____________________________________________

**INFECTIOUS DISEASE**
Tuberculosis
Hepatitis
Influenza
Shingles
STD
Blood Transfusion
HIV/AIDS
Other:_______________

- **Are you currently pregnant?** Yes No
- **Do You Smoke?** Yes No
- **Do You Drink Alcohol?** Yes No
- **Illicit Drug Use?** Yes No

**NERVOUS SYSTEM**
Stroke/TIA
Polio
Parkinson's Disease
Multiple Sclerosis
Epilepsy/Seizures
Concussion
Traumatic Brain Injury
Numbness or Tingling
Other:________________

**CANCER**
Type Of Cancer:
_________________________________
_________________________________
Date of Diagnosis: ________________
Treatments:
_________________________________
_________________________________
_________________________________

**ALLERGIES: PLEASE CIRCLE**
**LATEX ALLERGY**
**TAPE ALLERGY**
**OTHER ALLERGY-PLEASE**

Is there anything else we should know about your health?___________________________________________________________________________

***TELL US ABOUT YOUR CONDITION***
When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates)

First episode______________________ Subsequent Episodes_________________________ Most Recent Episode____________________________

How did your symptoms/injury occur?________________________________________________________________________________________________

Where are your symptoms located?__________________________________________________________________________________________________

What is your main problem related to this condition?____________________________________________________________________________

What makes your symptoms better?_______________________________ Worse?______________________________________________________

Have you had any surgery for your injury/condition?_______ If yes, what kind and when?_____________________________________________

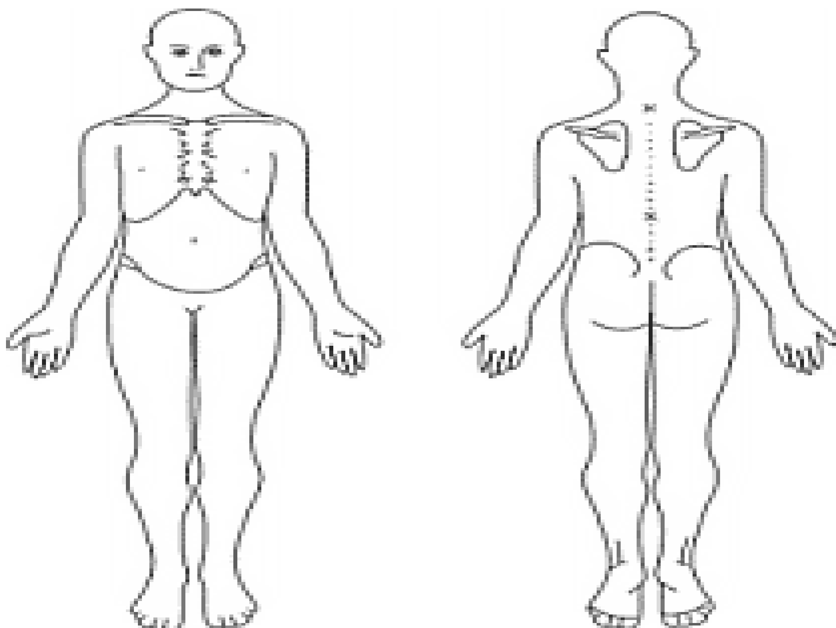
Have you received any injections for your injury/condition?______ If yes, when?____________________________ Did it help?__________________

Diagnostic tests performed (X-RAY, MRI, etc) ______________________________________________________________________________

For your current injury or condition, have you seen any of the following? (Please circle all that apply and specify approximate dates of treatment)
Medical Doctor ____________________ Physical Therapist ____________________ Psychiatrist/Psychologist __________________________
Chiropractor ______________________ Athletic Trainer _______________________ Personal Trainer ___________________________________

Are you exercising? _____ Describe:_______________________ Problems with exercise?_________ Describe:____________________________

What do you hope to accomplish with physical therapy?___________________________________________________________________________



On the diagram, please indicate your current symptom location (s) using they key below:

| Stabbing | ////// |
|---|---|
| Burning | XXXXXX |
| Numbness | ====== |
| Pins & Needles | 000000 |
| Aching | SSSSSS |

**Pain Rating Descriptions :**

0 No Pain
1-3 Achy, Sore Pain/No Restriction Of Function
4 Minor Restriction of Function
5 Moderate Restriction of Function
6 Severe Restriction of Function
7 Complete Restriction of Function
8-9 Hospital, Emergency Room Pain
10 Hot Poker In The Eye Pain

**Function Rating Descriptions:**

0 Unable to Function or get out of bed
10 Normal Function, The day before the injury occurred

**HEIGHT**________ **WEIGHT**__________

**BMI (Therapist Will Calculate)**________

How often do you experience your current symptoms? Always ☐ Frequently ☐ Occasionally ☐ Seldom ☐

Are your symptoms ? Not Changing ☐ Improving ☐ Getting Worse ☐

Using this scale (0 = no pain, 10 = emergency type pain):
My average level of pain is __________
My highest pain level in the last 30 days has been __________
My lowest pain level in the last 30 days has been __________

Using this scale (0 = no function, 10 = ability to perform normal daily activity):
My average level of function __________
My highest function level in the last 30 days has been __________
My lowest function level in the last 30 days has been __________

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**FOR THERAPIST USE ONLY**

I have reviewed past medical history with the patient/guardian prior to evaluation and treatment. The following was identified:

- ______________________________________________
- ______________________________________________
- ______________________________________________

I have informed the patient on our plan of treatment Y N
I have informed the patient of their outcome potential prior to treatment Y N

Therapist Signature: ______________________________________Date:____________________

I, ____________________________________ understand and accept the plan of care.
Patient/Guardian Signature

Patient/Guardian signature: ____________________________________Date:____________________

# *Summit Strength Physical Therapy, LLC*

***<u>MEDICATION LIST</u>***

***Patient Name:***_______________________________________________________________

***Food/Drug Allergies:***_________________________________________________________________

***Reaction:***_____________________________________________________________________

| ***Name of Medication:*** | ***Strength:*** | ***How Often Taken:*** | ***Comments:*** |
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# *SUMMIT STRENGTH PHYSICALTHERAPY, LLC*

## *SIGNED AUTHORIZATIONS*

***Phone # 816-524-7040  Fax# 816-524-7057  800 NW Main Street Ste. 100  Lee's Summit MO 64086***

**AUTHORIZATION FOR CARE**

I/we hereby authorize to receive care at Summit Strength Physical Therapy, LLC.  I/we understand that receiving physical therapy or strength and conditioning may involve stress of musculoskeletal tissue that may cause soreness, bruising,  and/or swelling  (like one might feel for a few days after starting a workout program such as running or lifting weights.)  Furthermore, I/we understand that the provider may need to perform mobilization technique, massage technique, manual traction, distraction, ultrasound, electrical stimulation, taping, bracing, orthotic fitting, tourniquet blood flow restriction therapy, weight training and other movement modalities that may produce brief (several days) soreness and discomfort.  It is my/our responsibility to communicate any difficulties that I/we are having during treatment to my/our provider.  It is also important to communicate any medical or activity changes that have occurred in my/our daily routine that may affect treatment decisions.

**PAYMENT POLICY**

I/we understand we are responsible to pay all co-pays, coinsurance and fees that are provided by Summit Strength Physical Therapy, LLC.  I/we understand that it is our responsibility to understand the percentage of coverage allowed by our insurance program and understand the coinsurance payments required.

**ASSIGNMENT & RELEASE**

I, the undersigned, assign directly to Summit Strength Physical Therapy, LLC all medical benefits, if any, otherwise payable to me for services rendered.  I understand that I am financially responsible for all charges whether or not paid by my insurance.  I herby authorize the physical therapist to release all information necessary to secure the payment of benefits.  I authorize the use of this signature on all my insurance submissions whether manual or electronic.  I also understand that if I have a co-pay it will be due at the time of service.

_______________________________________________________ ______________________________

Signature Date

**ACKNOWLEDGEMENT OF PRIVACY PRACTICE/HIPAA (Health Insurance Portability and Accountability Act)**

I acknowledge that I have received Summit Strength Physical Therapy, LLC's notice of Privacy Practices (HIPAA)

_______________________________________________________ ______________________________

Signature Date

**MEDICARE AUTHORIZATION (For Medicare Patients Only)**

I request that payment of authorized Medicare or Medigap benefits be made either to me on my behalf of Summit Strength Physical Therapy, LLC for any services furnished to me by a physical therapist.  I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.  I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.  If "other health insurance" or "Medigap" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.  In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services.  Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_______________________________________________________ ______________________________

Signature Date

**AUTHORIZATION FOR USE OF IMAGES**

I, the undersigned, hereby consent without further compensation or consideration, to allow images taken of me by Summit Strength Physical Therapy, LLC to be used by Summit Strength Physical Therapy for social media posting and other promotional publications.

_______________________________________________________ ______________________________

Signature Date

# SUMMIT STRENGTH PHYSICALTHERAPY, LLC

**Phone # 816-524-7040 Fax# 816-524-7057 800 NW Main Street Ste. 100 Lee's Summit MO 64086**

# CANCELLATION POLICY

*Due to the nature of our business, good communication between our staff at Summit Strength Physical Therapy and the patient is important for efficient scheduling for our clients. Our office greatly appreciates as much advance notice as possible for any reason you may need to cancel. Our staff has significant flexibility and understanding for last minute illness and issues that causes changes in the schedule. We appreciate advance notice so we can promptly call people on a waiting list and allow them to fill the spots that you have canceled. Our policy will be that if on any situation that you do not show for an appointment you will be charged $50.00 on your account for that visit. Cancellations made 48 hours in advance will not be charged. Cancellation of appointments not within 48 hours will be charged <u>$50.00 after 3 cancellations and thereafter</u>. You will also lose any prior scheduling arrangements (Preferred Continuous Time Slots) that are made.*

*I understand the cancellation policy for Summit Strength Physical Therapy, LLC.*

____________________________________ ___________________________

*Patient Name* *Date*