NEW PATIENT PAPERWORK – PRIVATE HEALTH INSURANCE

PATIENT INFORMATION	
Name:	Preferred:
Address, City, State, Zip:	
DOB:	Social security #:
Email Address:	

Home Phone:	Appointment Reminder Method
Cell Phone:	Home Phone ☐ Cell Phone ☐ Text ☐
Work Phone:	

Please keep in mind that communication via email over the Internet is not a secure form of communication. By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Partner's Name:
Financial Responsibility: ☐ Self ☐ Other
Emergency Contact:
Emergency contact phone: Relation:

Have you had Physical Therapy treatment since January of this year? ☐ Yes ☐ No # of visits:
Have you had Chiropractic treatment since January of this year? ☐ Yes ☐ No # of visits:
Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ No If yes, Home Healthcare Provider:

CONSENT TO TREATMENT
I hereby authorize and consent to treatment/services for myself, or on the behalf of the above-named patient, performed by the staff at Physical Therapy Central (PTC) or Redbud Physical Therapy and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the treatment plan that has been recommended. Signature Patient/Guardian and relationship to patient: Date:

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information.	
Primary Insurance:	Secondary Insurance:
Policy #:	Policy #:
Group #:	Group #:

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PAYMENT FOR SERVICES AND INSURANCE
I assign payment for these services directly to PTMS 3.0, LLC or RBPT. I authorize the filing of claims to my insurance plan and authorize PTMS 3.0, LLC or RBPT to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete. In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believed were covered services, resulting in my responsibility for paying for these services. I acknowledge that I am responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance plan and understand that I am fully responsible for any balance due for services rendered. Patient/Guardian Signature: Date:
Is this physical therapy care the result of an injury related to an Auto Accident, Third-Party incident, or Workers Compensation? ☐ Yes ☐ No **If yes, DO NOT CONTINUE. Please contact our office for the appropriate paperwork.**
NOTICE OF PRIVACY PRACTICE
I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other described and permitted uses or disclosures. I understand that I may contact the Confluent Health Compliance Officer listed on the notice if I have a question or complaint. Patient/Guardian Signature: _____ Date: _____ For questions, please contact the Compliance Department (Toll free) at 888-937-4479.

PATIENT HEALTH QUESTIONNAIRE
Occupation: Height: Weight: Sex: ☐ Male ☐ Female
Leisure Activities/Hobbies:
Are you? ☐ Right-handed ☐ Left-handed
Where do you live? ☐ Private home ☐ Apartment/rented room ☐ Assisted living/group home ☐ Hospice ☐ Other
With whom do you live? ☐ Alone ☐ Spouse only ☐ Spouse and others ☐ Child ☐ Other
Does your home have? ☐ Stairs, no railing ☐ Stairs, railing ☐ Ramps ☐ Uneven terrain Please explain:
How many times have you fallen in the past 12 months? Did it result in an injury? ☐ Yes ☐ No
During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No
General Health Status, please rate your health. ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PHYSICAL THERAPY CENTRAL REDBUD PHYSICAL THERAPY

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Please list any known allergies (including medications, latex, etc.) below:

Surgery / Hospitalization, please include date and reason.	

Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.						
Name	Dosage	Frequency	Please indicate route			
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other

Are you currently experiencing any of the following?			
Nausea or Vomiting	☐ Yes ☐ No	Chest Pains (Angina)	☐ Yes ☐ No
Productive/chronic cough	☐ Yes ☐ No	Pain wakes me at night	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Recent fever, chills, sweats	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Difficulty sleeping	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Visual problems	☐ Yes ☐ No	Heart palpitations	☐ Yes ☐ No
Hearing loss/ringing in ears	☐ Yes ☐ No	Loss of appetite	☐ Yes ☐ No
Difficulty walking	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Unusual weakness	☐ Yes ☐ No	Fatigue or myalgia	☐ Yes ☐ No
Joint pain or swelling	☐ Yes ☐ No	Unexplained weight changes	☐ Yes ☐ No

Have you been diagnosed with any of the following?			
Allergies	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Anxiety or Panic Disorders	☐ Yes ☐ No	Kidney Disease/Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Auto Immune Disease If yes, Type:	☐ Yes ☐ No	Metal Implants	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Bowel or Bladder Disorder	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Cancer If yes, Site:	☐ Yes ☐ No	Osteoarthritis	☐ Yes ☐ No
Cardiac Conditions	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No	Peripheral Vascular Disease	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Currently Pregnant	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Speech Problems	☐ Yes ☐ No

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Diabetes	☐ Yes ☐ No	Spinal Cord Stimulator	☐ Yes ☐ No
Emphysema/Bronchitis	☐ Yes ☐ No	Stomach Ulcers	☐ Yes ☐ No
Fractures	☐ Yes ☐ No	Stroke/TIA	☐ Yes ☐ No
Gall Bladder Problems	☐ Yes ☐ No	Thyroid	☐ Yes ☐ No
Gastrointestinal Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Hearing Loss	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Hepatitis If yes, Type:	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No

Social History / Wellness	
Do you drink alcoholic beverages?	☐ Yes ☐ No / Comments:
Do you use tobacco?	☐ Yes ☐ No / Comments:
How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? ☐ At least 3 times per week ☐ 1-2 times per week ☐ Seldom or Never	
Current Condition	
When did this problem(s) first begin?	
Describe the problem(s).	
Explain how problem(s) occurred.	
Have you ever had this problem before? ☐ Yes ☐ No If yes, how many times?	
Are your symptoms worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Same all day	
How are you taking care of the problem(s) now?	
My pain/problem is slowing getting: ☐ Worse ☐ Better ☐ Staying the same	
My symptoms bother me: ☐ Constantly (100%) ☐ Most of the time (75%) ☐ Occasionally (50%) ☐ Once in a while (25%)	
Do you have any numbness, tingling, or burning? ☐ Yes ☐ No If yes, please check one: ☐ Constantly ☐ Intermittently	
What functions could you perform before, that you now are unable to do?	
Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, ect.	

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Please list the dates and results of any:
X-Rays:
MRI:
Bone Density Test:
Nerve Conduction Test:
Other

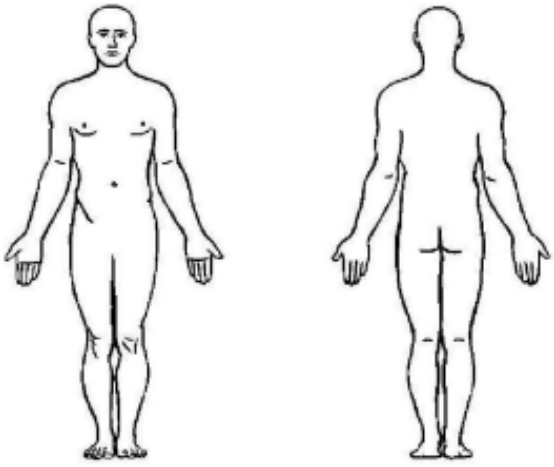
Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No If yes, please tell us what it is:
What are your goals for therapy?

Symptom Rating

Mark location of symptom(s)

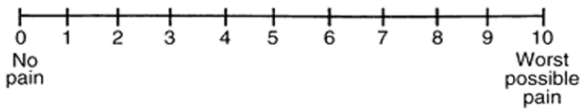
O for pain

X for numbness/tingling/burning

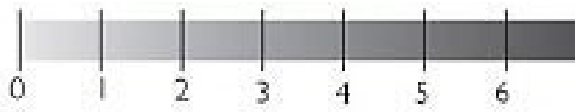


Please rate your pain - on a scale from 0 – 10
(0 = No Pain; 10 = Worst pain imaginable)

Current: / 10	Best: / 10	Worst: / 10



"I should not do physical activity which (might) make my pain worse."



Please rate your level of agreement on the scale below:

Completely Disagree Unsure Completely Agree

Patient/Guardian Signature: Date: