

# CHARLESTON PHYSICAL THERAPY

## New Patient Information Sheet

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information.

### Patient Information

Account #	Social Security #	Title	Last Name	First Name
Street Address (Road or Street)			(Apartment Number or Second Address Line)	
Zip Code	City	State		
Home Phone:	Cell Phone:	Patient Data: (Nick Name)/EMAIL ADDRESS		
Birthdate	Sex (M, F)	Referring Doctor full name	Primary Doctor full name	
Marital <input type="checkbox"/> M-Married <input type="checkbox"/> W-Widowed <input type="checkbox"/> S-Single <input type="checkbox"/> D-Divorced <input type="checkbox"/> X-Separated	Employment <input type="checkbox"/> R-Retired <input type="checkbox"/> F-Full <input type="checkbox"/> P-Part <input type="checkbox"/> N-None	Student <input type="checkbox"/> P-Part <input type="checkbox"/> F-Full <input type="checkbox"/> N-None	Relationship to Insured <input type="checkbox"/> SE-Self <input type="checkbox"/> SP-Spouse <input type="checkbox"/> OT-Other <input type="checkbox"/> CH-Child	
Employer Name				
Employer Street Address (Road or Street)				
Zip Code	City	State	Business Phone	Ext

### INSURANCE INFORMATION

Primary Insurance Company Name	Mailing Address			
Insurance Telephone #	Policy #	Group #		
Secondary Insurance Company Name	Mailing Address			
Secondary Telephone #	Policy #	Group #		

### COMPLETE IF INSURANCE IS IN SPOUSE'S/PARENT NAME

Social Security #	Title	Last Name	First Name	MI
Birthdate	Sex (M, F)	Relationship to Insured:		

### ACCIDENT DETAILS- Please complete if visit is due to injury

Employment related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Accident Related: <input type="checkbox"/> Auto <input type="checkbox"/> Other <input type="checkbox"/> No	Date of first symptom or accident: Give Details of Accident:
Have you had any physical therapy or speech therapy at any time this year? ___ Yes ___ No Have you had any home health services this year? ___ Y		

I authorize the release of any medical or other information necessary to process insurance claims.

I authorize payment of medical benefits directly to this practice for services rendered.

Signed

Date

Signed

Date

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Date: \_\_\_\_\_

Leisure activities, including exercise routines: \_\_\_\_\_

Occupation, including activities that comprise your workday: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Are you on a work restriction from your doctor? Yes No Are you latex sensitive? Yes No  
Do you smoke? Yes No Do you have a pacemaker? Yes No  
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No  
ALLERGIES: List any medication(s) you are allergic to: \_\_\_\_\_

Have you RECENTLY noted any of the following (check all that apply)?  
 fatigue  numbness or tingling  constipation  
 fever/chills/sweats  muscle weakness  diarrhea  
 nausea/vomiting  dizziness/lightheadedness  shortness of breath  
 weight loss/gain  heartburn/indigestion  fainting  
 difficulty maintaining balance while walking  difficulty swallowing  cough  
 falls  changes in bowel or bladder function  headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?  
 cancer  depression  thyroid problems  
 heart problems  lung problems  diabetes  
 chest pain/angina  tuberculosis  osteoporosis  
 high blood pressure  asthma  multiple sclerosis  
 circulation problems  rheumatoid arthritis  epilepsy  
 blood clots  other arthritic condition  eye problem/infection  
 stroke  bladder/urinary tract infection  ulcers  
 anemia  kidney problem/infection  liver problems  
 bone or joint infection  sexually transmitted disease/HIV  hepatitis  
 chemical dependency (i.e., alcoholism)  pelvic inflammatory disease  pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?  
 cancer  diabetes  tuberculosis  
 heart problems  stroke  thyroid problems  
 high blood pressure  depression  blood clots

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  
Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
- 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Have you ever taken steroid medications for any medical conditions? YES NO  
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

What date (roughly) did your present symptoms start? \_\_\_\_\_

What do you think caused your symptoms? \_\_\_\_\_

My symptoms are currently:  Getting Better  Getting Worse  Staying about the same

Treatment received so far for this problem (chiropractic, injections, etc) \_\_\_\_\_

Please list special tests performed for this problem (x-ray, MRI, labs, etc) \_\_\_\_\_

Have you ever had this problem before:  Yes  No When \_\_\_\_\_ Treatment rec'd \_\_\_\_\_

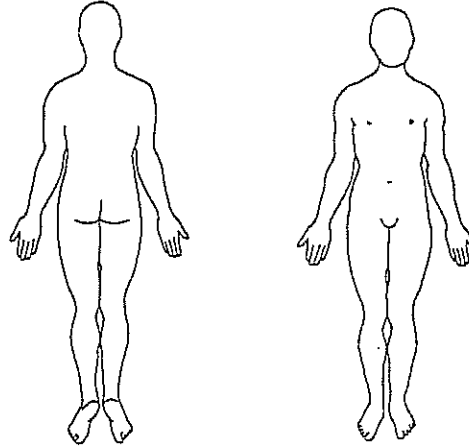
How long did it take for you to feel better? \_\_\_\_\_

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**Body Chart:**

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling



My symptoms currently:  Come and go  Are Constant  Are constant, but change with activity

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**Aggravating Factors:** Identify up to 3 important positions or activities that make your symptoms worse:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Easing Factors:** Identify up to 3 important positions or activities that make your symptoms better:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**How are you currently able to sleep at night due to your symptoms?**

No problem sleeping  Difficulty falling asleep  Awakened by pain  Sleep only with medication

**When are your symptoms worst?**  Morning  Afternoon  Evening  Night  After exercise

**When are your symptoms the best?**  Morning  Afternoon  Evening  Night  After exercise

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Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survey: \_\_\_\_\_

The best your pain has been during the past 24 hours: \_\_\_\_\_

The worst your pain has been during the past 24 hours: \_\_\_\_\_

# Charleston Physical Therapy

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

## HIPAA Notice of Privacy Practices Acknowledgment

I have received, read and understand your Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of Charleston Physical Therapy. I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Charleston Physical Therapy will consider requests, but does not have to agree to the request for restrictions. \_\_\_\_\_ Initials

## Authorization to Release and/or Obtain Medical Records

I hereby authorize all physicians participating in my healthcare, and Charleston Physical Therapy, to release, use, and disclose my entire medical record by mail, phone, and fax, to carry out my treatment, payment, and healthcare operations. \_\_\_\_\_ Initials

## Cancellation and No show Policy

Charleston Physical Therapy reserves the right to charge a \$25 fee for patients who do not give 24 hour notice for cancellation of scheduled appointments, or for patients who do not show for scheduled appointments. \_\_\_\_\_ Initials

## For Patients Entitled to Medicare Based on AGE

Are you or your spouse currently employed? \_\_\_\_\_ YES \_\_\_\_\_ NO  
If YES, do you have group health plan coverage based on your own or your spouses' current employment?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

## For Patients Entitled to Medicare Based on DISABILITY

Are you or your spouse currently employed? \_\_\_\_\_ YES \_\_\_\_\_ NO  
If YES, do you have group health plan coverage based on your own, or your spouses' current employment?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

## Authorized Methods of Communication (circle all that apply)

1. Okay to leave call back phone number only: Home Cell Work  
2. Okay to leave detailed message on answering machine/voice mail: Home Cell Work

## Emergency Contact

Name	Phone Number	Relationship
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By signing below, I acknowledge that this form has been read in full and explained as necessary.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date