

Patient Name: _____	OB: _____	Patient ID: _____
Current employment status? <input type="checkbox"/> Occupation _____ <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Disabled		
Work activities mostly include: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Computer <input type="checkbox"/> Driving <input type="checkbox"/> Varied <input type="checkbox"/> Other: _____		
How do you rate your health? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
When did your current symptoms begin? (date) _____ / _____ / _____ or (time period) _____		
Have you experienced these symptoms before (please explain)? _____		
Do you currently exercise, play sports or have hobbies (if yes, please describe)? _____		
How did your injury occur or symptoms begin (check all that apply)?		
<input type="checkbox"/> Accident – Work Related <input type="checkbox"/> Bending <input type="checkbox"/> Reaching <input type="checkbox"/> Other: <input type="checkbox"/> Accident – Motor Vehicle <input type="checkbox"/> Falling <input type="checkbox"/> No Apparent Reason <input type="checkbox"/> Accident – Liability / 3 rd Party <input type="checkbox"/> Lifting <input type="checkbox"/> Gradual Onset		
Indicate daily activities you are having trouble with due to this injury or onset of symptoms (check all that apply)?		
<input type="checkbox"/> Sitting minutes <input type="checkbox"/> Standing _____ minutes <input type="checkbox"/> Reaching <input type="checkbox"/> Dressing <input type="checkbox"/> Rising <input type="checkbox"/> Turning <input type="checkbox"/> Lying <input type="checkbox"/> Housework <input type="checkbox"/> Bending <input type="checkbox"/> Walking _____ feet <input type="checkbox"/> Sleeping _____ hours <input type="checkbox"/> Athletics <input type="checkbox"/> Driving <input type="checkbox"/> Stairs <input type="checkbox"/> Grooming <input type="checkbox"/> Other:		
What treatment & testing have you received (check all that apply)?		
<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Bracing <input type="checkbox"/> Nerve Conduction Study <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Orthotics <input type="checkbox"/> Myelogram <input type="checkbox"/> Chiropractic <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: <input type="checkbox"/> Injection <input type="checkbox"/> MRI <input type="checkbox"/> Medication <input type="checkbox"/> CT Scan		
If you had surgery , list the type of surgery _____ and date of surgery _____ / _____ / _____		
Do you currently have any "flu type" symptoms (i.e. fever, coughing)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what symptoms: _____		
Do you have any open cuts, lesions or wounds? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: _____		
Have you fallen in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times: _____		
If yes to falling, did you sustain an injury as a result of the fall? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you experience frequent episodes of the following (check all that apply)? <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Balance Control		
Have you noticed a change in your bowel or bladder frequency or control? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____		
Do you wear glasses or contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Patient Name: _____ **DOB:** _____ **Patient ID:** _____

Do you have, or have you had, any of the following (check all that apply)?

	Yes	No		Yes	No	List additional history:
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Previous Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Stroke History	<input type="checkbox"/>	<input type="checkbox"/>	

Use the following scales to rate your average symptom level (circle the appropriate level for each body part).
 "0" = No Symptoms, "10" = Intense enough to seek emergency assistance

Back: 0 1 2 3 4 5 6 7 8 9 10 **Arm:** 0 1 2 3 4 5 6 7 8 9 10 **Leg:** 0 1 2 3 4 5 6 7 8 9 10
Neck: 0 1 2 3 4 5 6 7 8 9 10 **Hand:** 0 1 2 3 4 5 6 7 8 9 10 **Foot:** 0 1 2 3 4 5 6 7 8 9 10

Please indicate on the chart below (reference the KEY), where specifically you feel the pain indicated above:

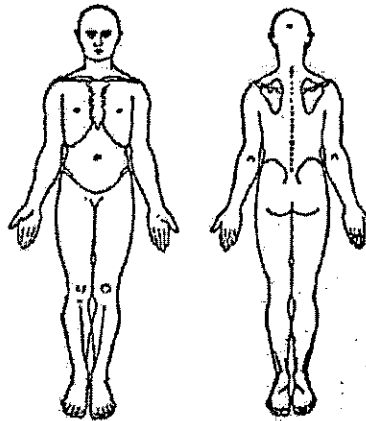
KEY

///// Stabbing

xxxxx Burning

00000 Pins & Needles

_____ Numbness



Do you take any medications (if Yes, please fill out below or you may provide a list of your medicines):

Prescription Medication	Dosage	Frequency	Medicine Route
			<input type="checkbox"/> Oral <input type="checkbox"/> Injection
			<input type="checkbox"/> Oral <input type="checkbox"/> Injection
			<input type="checkbox"/> Oral <input type="checkbox"/> Injection

Over the Counter Medications (Please circle any OTC medications that you take regularly): Aspirin / Ibuprofen, Antacids, Sleeping Aids, Cold Medicine, Cough Medicine, Allergy Relief, Laxatives, Vitamin/Herbal Supplements, Diet Pills

Do you have allergies to Latex Lidocaine Cortisone None Known Other:

Are you currently receiving home health services or have you within the last 4 weeks? Yes No

Have you had any physical, occupational or speech therapy this calendar year? Yes No

Do you have a family member or friend who can assist you during your recovery and with your care? Yes No

What goals do you have for therapy? What do you hope to accomplish?

My next appointment with my doctor is on _____ / _____ / _____ No appt scheduled.

Patient Signature: _____	Date: _____
Reviewed Health History with Patient: _____	Date: _____

DISABILITIES OF THE ARM, SHOULDER AND HAND

Patient Name / ID:

Date:

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing Frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

DISABILITIES OF THE ARM, SHOULDER AND HAND

Patient Name / ID: _____

Date: _____

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, to <i>what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups? (<i>circle number</i>)	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? (<i>circle number</i>)	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. (*circle number*)

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (<i>circle number</i>)	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. (<i>circle number</i>)	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE =
(Therapist will calculate)

$(((\text{sum of } n \text{ responses} / n) - 1) \times 25, \text{ where } n \text{ is the number of completed responses.})$

A DASH score may not be calculated if there are greater than 3 missing items.

Authorization and Guarantee

Patient Name:	Patient ID:
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INSURANCE BENEFITS (if applicable) :: As a courtesy, we will make every effort to contact your insurance company to obtain your therapy benefits. The benefit information obtained cannot be considered a guarantee of actual benefits or insurance payment for services rendered. We encourage you to contact your insurance company to verify your benefit information.

MEDICARE (if applicable) :: "I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and coinsurance."

GUARANTEE OF PAYMENT (not applicable for Worker's Compensation patients):: "In consideration of services rendered to me by PINNACLE Physical Therapy, I hereby guarantee payment for any and all services not covered or allowed by insurance. I also understand that all bills are due and payable upon receipt. I understand that the patient responsibility portion of my bill will be due and payable at the time of service. I understand that should my account with PINNACLE become delinquent and turned over to a collection agency, that I, the undersigned, will be responsible to pay all collection agency fees, court costs or any other fees / costs associated with resolving my account balance."

RETURNED CHECKS :: We are happy to accept your personal check, however, if your check is returned for any reason, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

CONSENT FOR TREATMENT :: "I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at PINNACLE Physical Therapy."

WAIVER AND RELEASE :: "I hereby release, discharge and acquit PINNACLE Physical Therapy, it's agents, representatives, affiliates, employees or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services."

AUTHORIZATION TO RELEASE MEDICAL INFORMATION :: "I consent to allow PINNACLE Physical Therapy, to use and disclose my protected health information (PHI) within PINNACLE to carry out my treatment, to obtain payment and to carry out health care operations. My PHI may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services and process medical claims. My PHI may be disclosed to outside health agencies or institutions involved in my continuing care and/or for emergency care purposes. My PHI may include medical information or any information pertaining to the evaluation, treatment and history. This may include psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical information and charges to my health plan and/or their intermediaries. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it. Withdrawal of consent shall be addressed in writing."

ASSIGNMENT OF BENEFITS :: "I authorize my health plan to pay benefits directly to PINNACLE Physical Therapy, LLC. I understand that in the event my health plan or healthcare contract does not cover services, I will be responsible for payment. I understand that if my health plan does not consider PINNACLE a participating provider, charges incurred will be paid by me. I further agree to accept full financial responsibility for payment of charges rendered to the above patient."

NOTICE OF PRIVACY :: "I acknowledge that a copy of the Notice of Privacy Practices is posted in the clinic and available for my review. Furthermore, I understand that I can request, and immediately receive, a copy of this document."

Patient / Legal Representative Signature X	Date:
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Cancellation/No-Show

Patient Name:	Patient ID:
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Welcome to Pinnacle Physical Therapy!

We work hard to stay on schedule because your time is valuable to us! Staying on schedule also allows us to provide you with the appropriate amount of time with your therapist to maximize the benefits of therapy and give you the best possible outcomes.

Some important reminders regarding your scheduled appointments...

- **No Shows - ** Please Note **** A \$25 fee may be charged to your account for all missed appointments in which prior notice of a cancellation was not provided to the clinic within 24 hours of your scheduled appointment.
- **24 Hour Notice!** - If you have to cancel an appointment, please provide us with at least 24 hours notice. Failure to do so may result in a \$25 charge being applied to your account.
- **Running Late?** - Please arrive on time for your scheduled appointments. If you are running late, please call ahead and let us know.
- **15+ Minutes Late?** - If you are running more than 15 minutes late, every attempt will be made to accommodate you. Your treatment may need to be modified or rescheduled in consideration of other patients with already scheduled appointments.
- **Frequent Cancelled or Missed Appointments** - If you regularly cancel or miss your appointments, we may ask that you return to your referring physician prior to scheduling any more therapy.

Thank you for your understanding and we are looking forward to serving you!

A COPY OF THE **CANCELLATION & NOW SHOW** POLICY IS AVAILABLE UPON REQUEST.

Patient / Legal Representative Signature x	Date:
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