RESTORE
PHYSICAL THERAPY

Thank you for choosing **RESTORE Physical Therapy. Our Mission** is: ***We Strive to Empower People to Live Healthy and Active Lives***. If you have any questions regarding your first appointment please visit our web site at www.restore-rehab.com and listen to the *First Visit* video or go to the FAQ section.

Our new patient appointments run on time, **please arrive 10 to 15 minutes prior** to your scheduled appointment, hand in your completed paper work and review your registration form. If you wait to complete your paperwork at our office, please arrive 30 minutes in advance. If you arrive exactly at your scheduled visit time for your first session, we may need to cut your session short if your paperwork is incomplete. Also, if you need to **cancel** or change your first appointment, please provide **at least 24 hours** notice so we can offer your scheduled time to another patient as your first appointment lasts 30 minutes to an hour with your physical therapist.

We look forward to participating in your care. Please see **RESTORE's** Promises and Expectations below.

We promise to:

- Welcome you into a caring, fun and professional environment.
- Listen with respect and respond to your concerns.
- Inform you the approximate cost of treatment in advance.
- Do our absolute best to keep your appointment on time.
- Perform our very best standard of physical therapy for you at all times.
- Make no charges for appointments changed or cancelled where 24 hours notice has been given.

We appreciate your commitment to:

- Arrive on time for your appointments.
- Sign-in upon arrival each visit and wait to be brought back to your treatment area.
- Give at least 24 hours notice if for some reason you need to cancel or change your appointment to avoid a cancellation charge.
- Follow our instructions for follow-up exercises.
- Attend review and maintenance appointments as advised.
- Pay for treatment, as required, prior to each visit. We accept cash, personal checks, debit cards and credit cards (Visa, MasterCard, Discover).
- Talk to us. Let us know what you think of what we do, right or wrong.

We are a small business and many of our referrals come from past patients. Please help our practice grow by recommending us to your family, friends and colleagues. If we provide exceptional care, will you do a review for us?

Please print the attached forms, complete and bring them with you to your first visit to speed your initial appointment's registration process.

Your Body. Your Life. Our Purpose.

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MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** ____/____/____ **Date:** ____/____/____

Are you presently working? ☐ Yes ☐ No; Occupation:_____ Last Day Worked: _____/_____/____

Work Status: ☐ Regular Duty ☐ Restricted/Light Duty ☐ Out of Work ☐ Retired ☐ Student ☐ N/A

Have you participated in physical therapy over the last year? ☐ Yes ☐ No; If yes, how many visits? _____

Have you fallen over the past year? ☐ Yes ☐ No; If yes, how many times? _____

Do you normally need a referral or preauthorization to see a specialist? ☐ Yes ☐ No : Date of next physician's visit: _____/_____/_____

Check which apply to your symptoms or injury:

☐ work related injury	☐ recurrence of previous injury	☐ chronic condition
☐ motor vehicle accident	☐ injury related to lifting	☐ injury related to a slip or fall
☐ cause unknown	☐ athletic / recreational injury	☐ other: _____

Do you have an attorney for this injury? ☐ Yes ☐ No; Attorney Name: _____ Phone Number: _____

Date of injury/onset: _____/_____/_____ Have you ever had physical therapy for these symptoms before? ☐ Yes ☐ No

Have you had a related surgery for this condition? ☐ Yes ☐ No ; Date: _____/_____/_____ Briefly explain below:

Have you been hospitalized for this condition? ☐ Yes ☐ No ; Dates: _____/_____/_____ to _____/_____/_____

Have you had home care services for this condition? ☐ Yes ☐ No ; Date of discharge: _____/_____/_____

_____

_____

Do you have, or have you had any of the following? (You must check either Yes or No. Do not leave any blank)

	Yes	No		Yes	No
Diabetes: Type 1 or Type 2	☐	☐	Allergies to Aspirin	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Ringing in your ears	☐	☐
Stroke/CVA	☐	☐	Dizziness / Fainting	☐	☐
Seizures	☐	☐	Nausea/ Vomiting	☐	☐
Kidney Problems	☐	☐	Headaches	☐	☐
Liver / Gallbladder Problems	☐	☐	Osteoporosis	☐	☐
Are you pregnant?	☐	☐	Rheumatoid Arthritis	☐	☐
Cancer	☐	☐	Pacemaker	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Metal Implants	☐	☐
Urine Leakage	☐	☐	Surgeries	☐	☐
Asthma / Breathing Difficulties	☐	☐	Recent Fracture	☐	☐
X-ray	☐	☐	EMG	☐	☐
MRI or CAT Scan (circle)	☐	☐	Are you a Smoker?	☐	☐
Bone Scan	☐	☐			

If you answered yes on any of the above, please briefly explain and give the approximate dates and results:

_____

_____

_____

Please list 2 Goals you would like to achieve with physical therapy? Example: (Sleep without pain. Walk without a walker.)

1. _____

2. _____

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Patient Name: _____ **Date of Birth:** ____/____/____ **Date:** ____/____/____

Are you presently taking Medication? ☐ Yes ☐ No

If yes, please list what medications (dosage and frequency) and for what condition:
(All four must be completed for each medication)

Medication: _____ Dosage: _____ Frequency: _____ Condition: _____
Medication: _____ Dosage: _____ Frequency: _____ Condition: _____
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Medication: _____ Dosage: _____ Frequency: _____ Condition: _____
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Medication: _____ Dosage: _____ Frequency: _____ Condition: _____
Medication: _____ Dosage: _____ Frequency: _____ Condition: _____
Medication: _____ Dosage: _____ Frequency: _____ Condition: _____
Medication: _____ Dosage: _____ Frequency: _____ Condition: _____
Medication: _____ Dosage: _____ Frequency: _____ Condition: _____

In case of an emergency, whom should we contact?

Name: _____ Relationship to patient:_____

Phone Number: _____

Prior to your injury, did you participate in any sports, exercise programs or activities on a regular basis?
☐ Yes ☐ No If yes, please describe.

_____

_____

If you work, how would you rate your work activity? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

_____ ____/____/____ _____
Patient's Signature Date Signature of Guardian if patient is a minor

I have reviewed the present and past medical history with the patient.

_____ ____/____/____
Therapist Signature Date

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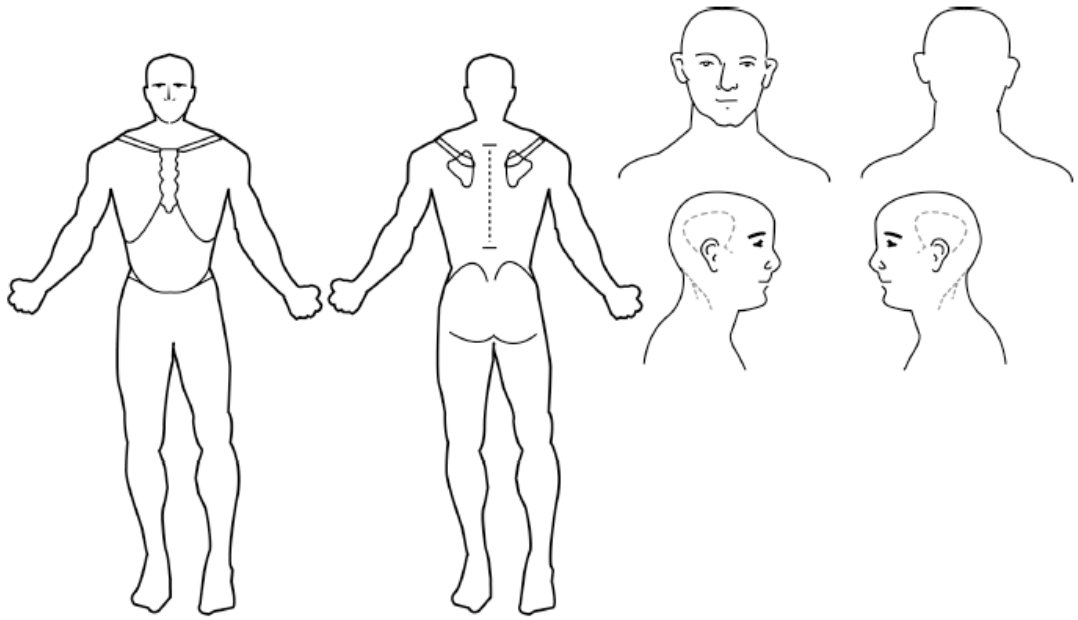
Patient Name: _____ Date of Birth: ____/____/____ Date: ____/____/____

Please indicate below where your symptoms are located. Use **X** marks where you have pain and //// marks to show where you feel numbness, tingling or pins and needles **TODAY**.



If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain imaginable. Please answer all three questions below. (Please circle number)
Please consider worse is worse and least is least even if you are doing no activity.

Please rate your **worse** pain over the last 3 days.

No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Worst Pain Possible

Please rate your **current** pain.

No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Worst Pain Possible

Please rate your **least** pain over the last 3 days. (Includes when at rest)

No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Worst Pain Possible

Which best describes the pain you have mostly: (Please Circle) None , Dull/Aching, Sharp, Throbbing, Burning, Numbness, Tingling, Constant, Intermittent, Radiating

If 100% is your goal (where you **want** to be), what percent of your goal would you rate yourself **currently**?
(0 to 100%) _____ %

Patient Name: _____ Date of Birth: _____
Initial Evaluation Date: _____/_____/_____

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

We appreciate the confidence you have shown in choosing us to provide for your rehabilitative needs. The services you have elected to participate in imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, RESTORE Physical Therapy will pre-verify your primary insurance carrier on your behalf. However, **if you have any questions you should contact your insurance company directly.** Ultimately you are responsible for payment of your bill.

The patient/guardian is responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Co-pays are due at the time of service. Your deductible/co-insurance are estimated and the remaining balance will be billed to you once we have received an "Explanation of Benefits" from your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim; or if you or your physician elects to continue therapy past your approved period, you will be responsible for your balance in full.

Balances older than 60 days will accrue a collection fee of 3% per month. A small administration fee will be charged to any account billed multiple times. There is also a $35.00 fee for returned checks.

I have read the above policy regarding financial responsibility to RESTORE Physical Therapy, L.L.C. for providing rehabilitative services to me, or the above named patient. I authorize my insurer to pay RESTORE Physical Therapy, L.L.C. the full and entire amount of the bill incurred by the above named patient; or, if applicable, any amount due after payment has been made by the insurance carrier.

PATIENT/GUATANTOR SIGNATURE: _____ DATE: _____

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize RESTORE Physical Therapy, L.L.C. through its appropriate personnel, to perform or have upon the above named patient or me, appropriate assessment and treatment procedures.

I further authorize RESTORE Physical Therapy, L.L.C. to release to appropriate agencies, any information acquired in the course of the above named patient's examination and treatment for treatment and billing purposes.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE:_____

(IF GUARANTOR IS NOT THE PATIENT)

HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the agencies HIPPA Notice of Privacy Practices. The notice provides, in detail, the uses and disclosures of my protected health information that may be made by RESTORE Physical Therapy, my rights as the patient and RESTORE's legal duty with respect to my protected health information. This notice is available for further review on our website at: http://www.restore-rehab.com/forms/hippa_notice_of_privacy_practices.pdf

PATIENT SIGNATURE: _____ DATE: _____

(Or parent if patient is a minor)

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Under HIPPA guidelines we are unable to discuss any part of your care (including appointment times, release of records, billing or your medical condition) to any individual in your family or representative of you without written authorization. Please complete this form if you wish to share your information. *You **do not** need to place physician names here.*

Patient Disclosure Authorization Form

Patient Name: _____ Date of Birth: _____

I authorize disclosure of my protected health information to the individual(s) named below.

Name	Relationship to Patient

Description of information to be released: (please check all that apply)

- ☐ Appointment Times
- ☐ Medical Records Release
- ☐ Billing Information
- ☐ Medical Condition/Prognosis
- ☐ Other (specify):_____

This authorization provides that:

- I may revoke this authorization at any time, provided that my request is made in writing to RESTORE Physical Therapy.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by HIPAA rules and regulations.
- I have a right to access my protected health information that will be used or disclosed.

Signature: _____ Date: _____

Relationship to patient (if signed by guardian/personal representative): _____

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Patient Name: _____ Date of Birth: ____/____/____ Date: ____/____/____

If you are using your insurance to pay for any of your care, please complete below. If you are paying self pay and not using insurance, you do not need to complete below. To ensure insurance reimbursement/payment, we are required to come up with **"Functional" goals** in establishing your **Plan of Care**. To do so, we need to create a clear picture of where you are now, where you would like to be and how you were functioning prior to your present injury/condition. Please answer the following questions which are relevant to your functional limitations to the best of your ability. Your therapist will review your answers at the time of your Initial Evaluation. If you have any questions or concerns just leave it blank and your therapist will clarify with you.

Please fill out the form as it pertains to the current injury/condition you are here to be treated for. If there are any questions or sections that do not relate to your current injury/condition, circle the appropriate answer (Yes / No) and proceed to the next question.

A. For All Injuries/Conditions:

1. Does your current injury/condition affect your:
   a. S**leep**? **Yes / No** (Circle one)
   b. Ability to **sit**? **Yes / No** (Circle one)
   c. Ability to **lift**? **Yes / No** (Circle one)
   d. Ability to **carry** things? **Yes / No** (Circle one)
   e. Ability to **wash** yourself? **Yes / No** (Circle one)
   f. Ability to **prepare food/cook**? **Yes / No** (Circle one)
   g. Ability to **drive** normally? **Yes / No ; N/A** (Circle one)

2. Does your injury/condition affect your ability to **dress**? **Yes / No** : If **yes**, answer below.
   a. Can you put your shirt on normally? **Yes / No** If **no**, answer below.
      i. ☐ I can not put my involved arm in a sleeve
      ii. ☐ I can only use button down the front shirts
      iii. ☐ I can only put a shirt on putting my involved arm in first
      iv. ☐ I am very slow and careful
   b. Can you put your pants on normally? **Yes / No** If no, answer below.
      i. Were you able to put your pants on normally prior? **Yes / No**
   c. Can you put your socks on normally? **Yes / No** If no, answer below.
      i. Were you able to put your socks on normally prior? **Yes / No**
   d. Can you put your shoes on normally? **Yes / No** If no, answer below.
      i. Were you able to put your shoes on normally prior? **Yes / No**
   e. **For females**: Can you put your bra on normally? **Yes / No** If no, answer below.
      i. Are you able to fasten your bra behind your back? **Yes / No**
      ii. Were you able to fasten your bra behind your back prior? **Yes / No**

B. For arm and neck injuries/conditions only.
Lower back and legs may skip to Part C

1. Does your injury/condition affect your ability to **reach overhead**? **Yes / No**
    a. If **yes**: What is the highest you can currently reach with the involved arm? (Check the highest one)
        i. ☐ Unable to lift the involved arm
        ii. ☐ Chest height
        iii. ☐ Shoulder height
        iv. ☐ Top of the head
        v. ☐ First kitchen shelf height
        vi. ☐ Second kitchen shelf height
        vii. ☐ Third kitchen shelf height
    b. **GOAL:** How high were you able to reach with the involved arm prior to your injury/condition? (Check the highest one)
        i. ☐ Unable to lift the involved arm
        ii. ☐ Chest height
        iii. ☐ Shoulder height
        iv. ☐ Top of the head
        v. ☐ First kitchen shelf height
        vi. ☐ Second kitchen shelf height
        vii. ☐ Third kitchen shelf height

2. Does your current injury/condition affect your ability to **groom** your hair normally? **Yes/No**
    a. If yes, I can groom:
        i. ☐ Only using my uninvolved arm
        ii. ☐ Using my involved arm I can do:
            1. ☐ Only the uninvolved side of my head
            2. ☐ Back of my head
            3. ☐ Top of my head
    b. I can use a blow dryer with both of my arms normally? **Yes / No** If **no**, answer below.
        i. I can only do with my uninvolved arm. **Yes / No**
        ii. **GOAL:** I was able to groom and use a blow dryer normally prior. **Yes / No**

3. Does your injury/condition affect your ability to **reach behind you back**? **Yes / No**
    a. If **yes**: What is the highest you can currently reach with the involved arm? (Check the highest one)
        i. ☐ The side of my involved hip
        ii. ☐ To my involved side back pocket
        iii. ☐ To the middle of my lower back
        iv. ☐ To my uninvolved side back pocket
        v. ☐ I am able to tuck in my shirt behind my back
        vi. ☐ I am able to wash my mid back region
        vii. ☐ For females: I am able to fasten and undo my bra behind my back

b. **GOAL:** How high were you able to reach behind your back with the involved arm prior to your injury/condition? (Check the highest one)

i. ☐ The side of my involved hip
ii. ☐ To my involved side back pocket
iii. ☐ To the middle of my lower back
iv. ☐ To my uninvolved side back pocket
v. ☐ I am able to tuck in my shirt behind my back
vi. ☐ I am able to wash my mid back region
vii. ☐ For females: I am able to fasten and undo my bra behind my back

C. For lower back and leg conditions only. (Arm and neck patients are finished.)

1. Does your current injury/condition limit your **standing**? **Yes / No** (Circle one)
   a. **GOAL:** How long would you like to stand? _____
2. Does your current injury/condition affect the distance or time you are able to **walk** currently, with or without an assistive device? **Yes / No**
   a. **GOAL:** How far would you like to walk? _____ (Blocks or Miles)
3. Does your current injury/condition affect your ability to walk up and down **stairs** normally? **Yes / No**
   a. **GOAL:** Were you able to do stairs normal prior? **Yes / No**
4. Does your current injury/condition require you to use an **assistive device** with walking? **Yes / No**: If **yes**, check one below.
   a. If **yes**, check one below.
      i. ☐ I am unable to walk and use a wheel chair.
      ii. ☐ I use a walker. With or without wheels? (circle one)
      iii. ☐ I use two crutches
      iv. ☐ I use one crutch
      v. ☐ I use a cane
      vi. ☐ I only use an assistive device when I walk outside.
         1. Please specify what device you use outdoors. _____
   b. Did you require an assistive device with walking prior to your current condition? **Yes / No** : If yes, check one below.
      i. ☐ I was unable to walk and used a wheel chair.
      ii. ☐ I used a walker. With or without wheels? (circle one)
      iii. ☐ I used a cane
      iv. ☐ I only used an assistive device when I walk outside.
         1. Please specify what device you used outdoors. _____

Thank you for your time in completing this form and we are looking forward in returning you to a healthy and active lifestyle.