



RED CANYON PHYSICAL THERAPY PATIENT HISTORY FORM

Patient Name:

Age:

Today's Date:

History of Injury/Symptoms

Primary complaint/Reason for attending PT:

Date of injury or problem begin?

Date of Surgery?

What caused your problem to begin (select one of the following:) Wear and Tear Car accident Work injury Sports injury Other

Have you had any other treatment for this condition?

Have you ever had PT before? Yes No If "Yes" when was last time you had PT?

What tests have been done? X-ray MRI CAT Scan EMG Bone Scan Nerve Conduction

Test Result(s):

Current Medication:

Check any other medical conditions you now have or have had in the past. (Select all that apply)

- Diabetes, High Blood, Heart Disease, Cancer, Heart Attack, Kidney Disease, Liver Disease, Headaches, Stroke, Osteoporosis, Seizures, Nervous Disorders, Depression, Currently Pregnant, Thyroid Disease, Arthritis, Anemia, Dizziness/Fainting, Fractures, Hepatitis/HIV

Other:

Allergies (please list):

Recent surgery or hospitalizations? (please list):

Do you have a pacemaker or any metal implants? Yes No

Pain Level: Mark on the scale what level your pain is:

At its WORST:

Where is your pain? Circle on the drawings below the areas where you feel your pain:

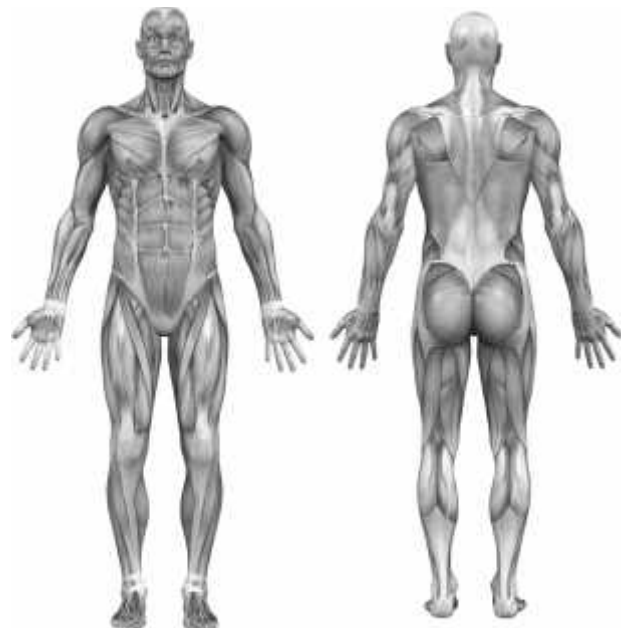
At its BEST:

Is the pain: Constant intermittent

Is your Condition: Improving Getting Worse Not Changing

SIGNATURE OF PATIENT:

REVIEWED BY PT:





PATIENT HISTORY FORM

Patient Name:

Date:

Please Initial

Consent to Treatment: I consent to rehabilitation and related services at Red Canyon, LLC. In doing so, I understand, acknowledge and affirm that such rehab and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

Cancellation Policy: If I cancel or do not show for an appointment within 24 hours of the appointment date, I understand that I may be charged a \$25 fee.

Treatment of Minors: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premise during any such treatment, and waive any claim I may have resulting from failure to do so.

Liability: I know and agree that Red Canyon, LLC is not responsible for loss or damage to personal valuables.

Waiver and Release: I hereby release, discharge, and acquit Red Canyon, LLC, its 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 of Payment: I hereby assign all benefits directly to Red Canyon, LLC and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice Of Privacy Practices.

Notice of Privacy: I acknowledge receipt of the Notice of Privacy Practices.

Benefit Information: Upon your first visit to the office, you will sign a benefits information sheet based on the most current information provided to us. Per the insurance disclaimer, this information is not a guarantee of payment and subject to all applicable policy restrictions. Should this information be misquoted, we cannot be held liable. If you wish to call your carrier to verify your benefits our staff can provide you with assistance.

Exceeding Authorization: Certain carriers have restriction and limitations on Physical Therapy services. Therefore it is the patient's responsibility to ensure these restrictions are not exceeded. Should these restrictions be exceeded patients will be granted the self-pay courtesy rate per our current policy.

I certify that all the above information provided is true and correct. I hereby, authorize and instruct my insurance carrier to pay Red Canyon, LLC directly for any physical therapy services performed. Additionally, I understand that I am financially responsible for payment of all co-pays, deductibles and balances not covered by my insurance carrier, provided my specific plan does normally pay for the services and/or products rendered to me by the medical providers at this facility. In the event an outstanding balance is referred to an attorney for collection, I will be responsible for all costs of collection to include but not limited to litigation expenses, court costs, service of process fees and attorney's fees not to exceed twenty(20%) percent of the outstanding balance. I also waive the right to claim statute of limitations as a defense in any collection action and that any outstanding balance may accrue interest at a rate of eighteen(18%) percent per annum.

Patient/Guardian Signature:

Witness Signature:



PATIENT HISTORY FORM

The Patient-Specific Functional Scale

This useful questionnaire can be used to quantify activity limitation and measure functional outcome for patients with any orthopedic condition.

Clinician to read and fill in below: Complete at the end of the history and prior to physical examination.

Initial Assessment:

I am going to ask you to identify up to three important activities that you are unable to do or are having difficulty with as a result of your _____ problem. Today, are there any activities that you are unable to do or having difficulty, with because of your _____ problem? (Clinician: show scale to patient and have the patient rate each activity).

Follow-up Assessments:

When I assessed you on (state previous assessment date), you told me that you had difficulty with (read all activities from list at a time). Today, do you still have difficulty with: (read and have patient score each item in the list)?

Patient-specific activity scoring scheme (Point to one number):

0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity									Able to perform activity at the same level as before injury or problem	

(Date and Score)

Activity	Initial						

Total score = sum of the activity scores/number of activities
 Minimum detectable change (90%CI) for average score = 2 points
 Minimum detectable change (90%CI) for single activity score = 3 points

PSFS developed by: Stratford, P., Gill, C., West away, M., &Binkley, J. (1995). Assessing disability and change on individual patients: a report of a patient specific measure. *Physiotherapy Canada* 47, 258-263.

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PATIENT HISTORY FORM

PatientName:

Date:

Calculate BMI and Select Appropriate Box

BMI =Weight (lb)X703

[Height (in) X Height (in)]

Weight(lbs):

Height(inches):

Age 65 years and older:

Within Normal Parameters [BMI = ≥ 23 and < 30]

Above Normal Parameters [BMI ≥ 30]

Below Normal Parameters [BMI < 23]

Ages 18 – 64 years:

Within Normal Parameters [BMI= ≥ 18.5 and < 25]

Above Normal Parameters [BMI ≥ 25]

Below Normal Parameters [BMI < 18.5]

BMI=

Note:Documentationofafollow-upplanisrequiredwhenBMIisoutsideofnormal parameters.

Patient Signature

Evaluating Therapist/Credentials

Date