RANCHO PHYSICAL THERAPY

PATIENT INFORMATION

Today's Date: _____

Name: _____ SS#_____/_____/_____
First MI Last (Required for Work Comp Only)

◯ Male ◯ Female Date of Birth: _____/_____/_____ Home: (_____) _____-_____ Cell Phone: (_____) _____-_____

Address: _____
Street Address City State Zip Code

Would you like to receive reminders by email? ◯ Yes ◯ No Would you like to receive reminders via text message? ◯ Yes ◯ No

Email Address: _____ Claim #: _____ Date of injury: _____/_____/_____

Employer (**AT TIME OF INJURY**): _____ Employer Phone: (_____) _____- _____

Employer Address: _____
Street Address City State Zip Code

Emergency Contact: _____ Ph: (_____) _____-_____ Relationship: _____

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Fortanasce Physical Therapy.

Signature: _____ Date: _____

ACKOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand RPT reserves the right to modify the privacy practices outlined in the notice and I have received or been offered a copy of the Notice of Privacy Practices for RPT.

Signature: _____Date:_____ Received / Offered (circle one)

NON-COMPLIANCE NOTIFICATION

Your therapist, physician, adjuster and case manager, work together to assist with your return to full function in the workplace. In order for your treatment to have maximal effect and progress, all prescribed therapy sessions must be attended. To comply with the workers' compensation laws, we are required to notify the adjuster, case manager and physician of missed appointments. If for any reason, you are unable to attend, please call in a timely manner and we will reschedule your appointment and inform your adjuster. Missed appointments may result in discontinuation of workman's compensation benefits.

FINANCIAL POLICY

In the event, that my Work Comp claim is denied by the Workers' Compensation Carrier, Rancho Physical Therapy will not transfer charges to an attorney lien that were assessed prior to the date the claim was denied. I understand and agree that I become the responsible party and liable for payment of all charges assessed for professional services rendered. I agree to pay any sum due, upon demand. I understand and agree that if it becomes necessary for Rancho Physical Therapy to utilize an outside collection agency, or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance and in addition, attorney fees, court costs and other expenses of litigation.
I have read and understand the non-compliance notification and financial policy. I do herby acknowledge that all information given true and factual.

Signature: _____ Date: _____

WORKER'S COMPENSATION CARRIER / ATTORNEY & ADJUSTER INFORMATION

ADDITIONAL CONTACTS, PLEASE PROVIDE TO FRONT OFFICE STAFF

Carrier: _____ Adjuster's Name: _____ Adjuster's Phone: (_____) _____ -_____

Claims Mailing Address: _____
Street Address City State Zip Code

Attorney Name: _____ Attorney's Phone: (_____) _____ -_____

Mailing Address: _____
Street Address City State Zip Code

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinson's	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

HEIGHT: _____ WEIGHT: _____

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

☐ Injury as a result of a fall in the past year? Date of injury or onset: _____

☐ Two or more falls in the last year?

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____/_____/_____

Body Region: _____ Surgery Type: _____ Date: _____/_____/_____

Body Region: _____ Surgery Type: _____ Date: _____/_____/_____

Body Region: _____ Surgery Type: _____ Date: _____/_____/_____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

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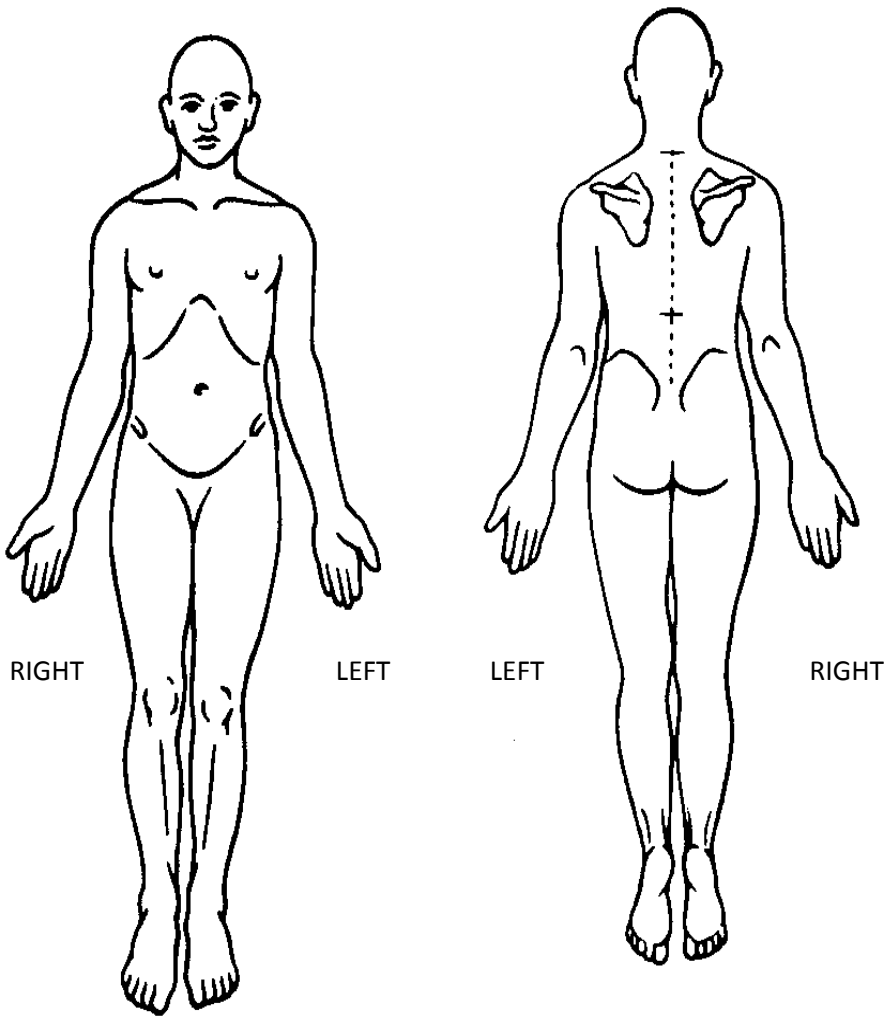
Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

☐ **Currently not taking any medications**

Rancho Physical Therapy

Graphic Pain Assessment

PAIN INTENSITY SCALE	PAIN LOCATION BODY DIAGRAMS
10 Pain as bad as it could be 9 Excruciating 8 7 Severe 6 5 Moderate 4 3 Mild 2 Slight 1 0 No Pain	

1. Draw a line on the pain intensity scale at the point that best describes your pain at the present time.
2. Draw the location of your pain on the body diagrams above.
3. If you have any other symptoms, such as tingling or numbness, draw these as a dotted line.

Please describe the details of your injury, including the date of injury and any treatment of the injury: