University Physical Therapy Initial Visit Form

Date: _____ Age: _____ Height: _____ Weight: _____

Name: _____

Smoker? Y N Gender? M F Pregnant? Y N

Employment / Occupation:

FT / PT / FD / MD / OOW

Describe your regular exercise routine:

Past Surgical History (list all and date):

_____

_____

List Current Medications

_____

_____

Have you had an X-Ray, MRI or other imaging study?

_____

Findings: _____

Past Medical History: please circle each condition tthat you have been told you have (or had)

Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Heart Disease/Agina/Chest Pain		Ulcers	Fibromyalgia
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Sexually Transmitted Disease	
Allerges / Asthma	Lung Disease	Have you had a recent illness (explain if yes)? _____		

Do you take blood thinners? Y N Are you allergic to latex Y N Other?

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes No
During the past month, have your often been bothered by little interest or pleasure in doing things? Yes No

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Currently I am experiencing (circle all that apply):

Unexplained weight loss	Numbness/tingling	Fever/chills/sweats	Poor balance (falls)
Depression	Shortness of breath	Changes in Appetite	Dizziness
Changes in bowel or bladder function		Difficulty Swallowing	Headaches
		Nausea	Increased pain at night

Current Symptoms:

Where are you currently having symptoms? _____

What date (approximately) did your present symptoms start? _____; did they come on gradually or suddenly

How did they start? _____

Symptoms are currently: Getting better / About the same / Getting worse

Before now, have you received treatment for this current problem (describe)? _____

Have you have this problem before? Yes No

If so, how was the problem treated? _____

How long did it take for you to feel better? _____

How are you able to sleep at night: Fine Moderate difficulty Only with medication

Preferred sleeping position: Front Back Right side Left side I toss and turn

What is your personal goal for therapy? _____

Do you have any barriers to learning (please list if so)? _____

CONSENT: I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered: _____ (sign)

Continue on Reverse Side Please

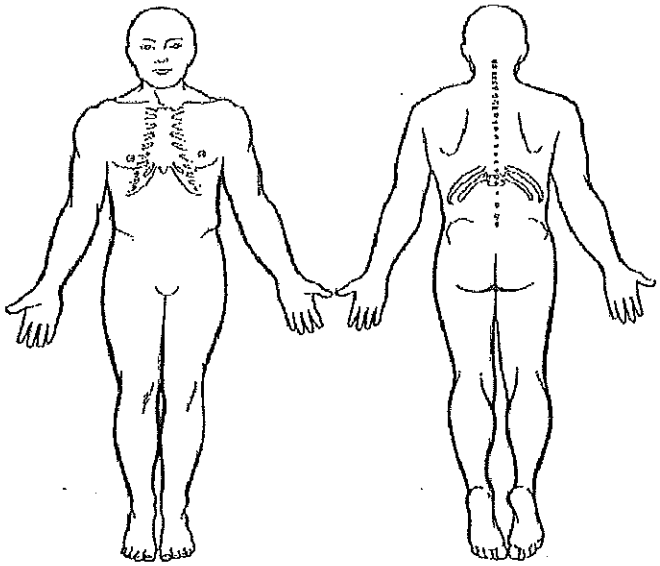
On the scales below, please circle the number which best represents the severity of your pain

Average for the past 48 hours:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Best for the last 48 hours:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Worst for the last 48 hours:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Body Chart: Please mark the areas where you feel symptoms (pain, numbness, lack of feeling:



For the Therapist - Subjective

Outcomes testing: Oswestry / FABQ / LEFS / DASH / NDI /
+/- Saddle Anesth +/- Cough/Sneeze

Please circle the number below which best represents your overall average level of function
Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 Able to do everything

What makes your symptoms better? _____

Please circle the activities that make your symptoms worse:
Lying down Standing Walking Stress Sitting Squatting

Any other activities that make your symptoms worse? _____

Please list your best and worst times of day for your symptoms:
Best: _____ Worst: _____

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem:

1) _____

2) _____

3) _____

Thank you for your help with this form.
Stop here, the rest of this form is for your therapist

University Physical Therapy
Intake/Billing Form

Name: _____ Date of Birth: _____Age_____

Local Address:

_____ SS # ____-____-_____

Student ID #_____

_____ Home Phone: #_____

Email _____ Cell Phone # _____

Students:
Parent's Address (if different from above) Parent's Phone: #_____

_____ **Is This related to:**

_____ **( ) Auto Accident ( ) Work Related Injury**

Type of Insurance
Subscriber's Name:_____

( ) Blue Cross/Blue Shield
ID# _____

( ) United Health Care
ID# _____

( ) Student Insurance (additional form required)
ID# _____

( ) Other (specify)
Type_____

ID# _____

Referral Information:

Referring MD: _____

( ) RI ( ) Other_____

Diagnosis: _____

Agreement of Responsibility

I agree to pay for all co-pay charges, and for services not covered by insurance.

Signature:_____ Date:_____

The University of Rhode Island
University Physical Therapy

Independence Square, URI, Kingston, RI 02881
Phone: (401) 874-2006 fax: (401) 874-5630

Patient Consent

We ask that you take a few minutes to review the following information. In this way, we hope to give you a better understanding of the role of physical therapy and of the Physical Therapist in your rehabilitation.

Who are Physical Therapists?

Physical therapists (PTs) are now educated at the doctorate level, and are licensed health care professionals who can help patients reduce pain and improve or restore mobility. Physical therapists (PTs) can teach patients how to prevent or manage their condition so that they will achieve long-term health benefits. PTs examine each individual and develop a plan, using treatment techniques to promote the ability to move, reduce pain, restore function, and prevent disability. In addition, PTs work with individuals to prevent the loss of mobility before it occurs by developing fitness- and wellness-oriented programs for healthier and more active lifestyles

PTs use a variety of hands-on techniques with or without tools, therapeutic exercise, and/or machines to re-establish proper posture, control pain, and restore movement and function. Physical Therapists are not physicians, and do not make medical diagnoses. Physical Therapists do not order radiological or laboratory tests.

What Can I Expect During My Course of Treatment?

A Physical Therapist typically uses a thorough evaluation process to shed light on potential and existing problems with movement and function. With you, they will formulate goals and plan treatments to achieve those goals. Treatments typically consist of active components such as therapeutic exercise for balance, control, strength or flexibility, and passive components when the therapist may use a variety of hands-on techniques, and/or tools and machines to meet your treatment goals.

Are There Risks?

There are risks for any type of treatment. However, the risk of serious injury from a treatment provided by a Physical Therapist is very low; less than flying in an airplane, driving a car, or taking most kinds of medication. Because of the unfamiliar nature of some exercises, movements or therapeutic procedures, you may experience some post-treatment muscle or joint soreness or aching. These sensations should decrease rapidly and disappear within a day or two. Joint manipulation and triggerpoint dry needling (TDN) can result in a short-term increase in pain and some soreness for a day or so after the treatment. In addition, TDN can result in bruising, a few drops of blood, infection, muscle or nerve irritation or a feeling of faintness or sweating during the treatment. More serious risks can occur, however, these are extremely rare. For joint manipulation there is a very small risk of joint dislocation or bone fracture. For TDN, these include puncture of the lung or bowel, and damage to the brainstem or spinal cord. Due to the nature of the needle used for TDN, the likelihood of significant tissue trauma is highly unlikely.

If you are concerned about the procedures used in your treatment, or about the results of those procedures, we encourage you to discuss your concerns with your Physical Therapist.

I have read this disclosure statement and consent to participation in physical therapy.

_____ _____

(Patient Signature) (Date)

University Physical Therapy
Co-pay/Co-insurance Information

A co-pay is a fixed amount that a patient owes per physical therapy visit. **It is determined by your insurance company, not the PT provider.**

A co-insurance is a percentage that a patient owes per physical therapy visit. This is based upon the amount that your insurance reimburses for services. This depends on your individual treatment and insurance plan.

United Health Care Student Insurance has a 10% co-insurance.

United Health Care State Employee has a 20% co-insurance.

Blue Cross Blue Shield and Blue Chip co-pay depends on your individual plan. Call the member services number on the back of your card for specifics.

For all other insurances and out of state insurances call the member services number the your card for details for physical therapy coverage (co-pay, co-insurance, limit of number of visits, in network vs. out of network coverage, deductible)

It is the patient's responsibility to be aware of their co-pay/co-insurance and deductibles.

Invoices will be sent out periodically to the address on file for payment.

For questions contact Gail in the office on Tuesdays between 8a-4p and Thursdays from 1-4p at 401-874-2006.

I have read and understand my responsibility for payment.

Patient signature _____ Date _____

UNIVERSITY PHYSICAL THERAPY

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

With my consent, University Physical Therapy:

- may use and disclose protected health information (PHI) about me to carry out treatment, payment and health operations (TPO). (Please refer to our Notice of Privacy Practices) for more complete description of such uses and disclosures.
- may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care.
- may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder card and patient statements as long as they are marked Personal and Confidential.

I have the right to request that University Physical Therapy restricts how it uses or discloses my PHI to carry out TPO, however, the clinic is not required to agree to my requested restrictions, but it is bound by this agreement.

I realize that I have the right to review the Notice of Privacy Practices prior to signing this consent and that I may request a copy of the same. University Physical Therapy reserves the right to revise its Notice of Privacy Practices at anytime. The current Notice of Privacy Practices may be obtained by forwarding a written request to University Physical Therapy, 25 West Independence Way, Suite, Kingston, RI 02881. Attn:Gail Gendron.

By signing this form, I am consenting to University Physical Therapy's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, University Physical Therapy has the right to decline treatment to me.

Other persons to whom I authorize disclosure of my PHI at this time are:

_____

_____ _____ _____

Patient's Name Signature of Patient or Legal Guardian Date

Accepted by _____ for University Physical Therapy

_____

Date