Advanced Therapy Solutions

Patient First Name_____

Address_____City_____State_____Zip_____

Social Security #_____-_____-_____Date of Birth____/____/_____ Sex: M or F

Drivers License #_____Marital Status: Single, Married, Divorced

Email Address:_____@_____

Home Phone #_____Cell Phone #_____

Employer_____Phone #_____

Address_____City_____State_____Zip_____

In case of emergency

Notify_____Phone #_____

_____

If patient is a minor :Guardian_____Relationship_____

Address_____City_____State_____Zip_____

Home phone_____Social Security #_____ Sex: M or F

Drivers License #_____Date of Birth_____/_____/_____

Health and Insurance Information

Insurance Name_____Phone #_____

ID or Claim #_____Group #_____

Insured's Name_____ SS#_____

Birthdate_____

Employer _____Phone #_____

Do you have secondary Insurance? Yes or No

If yes, Insurance Name _____Policy#_____

Is this a work related injury? Yes or No

If yes, Date of Injury?_____

Worker's Comp Adjustor_____

Worker's Comp Claim #_____

Is this an Auto related injury? Yes or No

If yes, Date of accident?_____

Name of attorney_____

Have you had PT for this condition? Yes or No

If yes, Previous PT Provider_____

If covered under Medicare or Medicare replacement, answer the following questions:

Are you currently receiving Home Health or Provider Services? Yes or No

If yes, from whom?_____

Do you live in a nursing home? Yes or No

If yes, location?_____

Are you covered under Black Lung Disease? Yes or No

Are you covered by End Stage Renal Disease? Yes or No

Please have your insurance card(s) and driver's license available for us to make copies.

Assignment of insurance Benefits: I assign all medical benefits to which I am entitled to be paid directly to Advanced Therapy Solutions. 1530 Springhill Rd. Suite B. Jasper Texas 75951. A photocopy of this assignment is to be considered as valid as the original. Treatment Consent: I hereby give consent for physical therapy to be administered to me or minor patient by persons in this office in acceptable, professional standards. Financial Agreement : I understand that all payments designated as "the patient's responsibility" such as co insurance, co-pays, and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed my responsibility within the statement due date.

_____ _____

Patient or Guardian Signature Date

CURRENT CONDITION(S) CHIEF COMPLAINT(S)

Have you ever had the problem(s) before? Yes or No

If yes, what did you do for the problem(s)? _____

Did the problem get better?_____

Date & Location of PT _____

How are you taking care of the problem now?_____

What makes the problem better?_____

What makes the problem worse? _____

What are your goals for physical therapy? _____

Date of next appointment with the Dr. who ordered therapy? _____

Are you seeing anyone else for the problem(S)? Yes or No.

If yes whom? _____

Please circle: Are you-- right handed or left handed.

MEDICAL / SURGICAL HISTORY

PLEASE CIRCLE IF YOU HAVE ANY HISTORY OF ANY OF THE FOLLOWING:

PACEMAKER	LUNG PROBLEMS	PARKINSONS DISEASE	ULCERS/STOMACH PROBLEMS
BROKEN BONES OR FRACTURES	STROKE	SEIZURES/EPILEPSY	SKIN DISEASE
OSTEOPOROSIS	DIABETES/HIGH BLOOD SUGAR	DEVELOPEMENTAL/GROWTH	DEPRESSION
ARTHRITIS	LOW BLOOD SUGAR/HYPOGLYCEMIA	THYROID PROBLEMS	CANCER
CIRCULATION/VASCULAR PROBLEMS	BLOOD DISORDERS	INFECTIOUS DISEASES	HEAD INJURY
HEART PROBLEMS	MULTIPLE SCLEROSIS	KIDNEY PROBLEMS	OTHER----------
HIGH BLOOD PRESSURE	MUSCULAR DYSTROPHY	REPEATED INFECTIONS	LATEX/LOTION ALLERGY

WITHIN THE PAST YEAR HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

CHEST PAINS	COORDINATION PROBLEMS	DIFFICULTY SLEEPING	URINARY PROBLEMS
HEART PALPITATIONS	WEAKNESS IN ARMS OR LEGS	LOSS OF APPETITE	FEVER/CHILLS/SWEATS
COUGH	LOSS OF BALANCE/FALLS	NAUSEA/VOMITING	HEADACHES
HOARSNESS	DIFFICULTY WALKING	DIFFICULTY SWALLOWING	HEARING PROBLEMS
SHORTNESS OF BREATH	JOINT PAIN OR SWELLING	BOWEL PROBLEMS	VISION PROBLEMS
DIZZINESS OR BLACKOUTS	PAIN AT NIGHT	WEIGHT LOSS/GAIN	OTHER_____

HAVE YOU EVER HAD SURGERY? IF YES, PLEASE DESCRIBE AND INCLUDE DATES:_____

_____

_____

FOR WOMEN ONLY- ARE YOU PREGRANT OR THINK YOU MIGHT BE? YES OR NO

MEDICATIONS: (*You may make a copy of a list and supply for your chart*)

NAME OF MEDICATIONS	DOSAGE & FREQUENCY	NAME OF MEDICATIONS	DOSAGE AND FREQUENCY
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

GENERAL HEALTH STATUS

Do you currently use tobacco products? Yes or No

If yes, what type and how much per day? _____

Do you exercise beyond your normal daily activities and chores? Yes or No.

If yes, describe the exercises._____

On average, how many days/minutes per week do you exercise or do physical activity? _____

SOCIAL HISTORY

Any cultural or religious beliefs that might affect care?_____

Does your home have: please circle

Stairs, no railing Elevators Any obstacles_____

Stairs railing Uneven terrain Ramps Assistive devices

Do you use any of the following?

Cane Manual wheelchair Contacts Walker Motorized wheelchair Glasses

Crutches Hearing Aids Other_____

Employment (please circle)

Working full time outside the home Homemaker

Working full time from the home Student

Working part time outside the home Retired

Working part time inside the home Unemployed

Occupation (what type of work do you perform)_____

Signature_____ Date_____

Photo Release

I hereby give permission to Advanced Therapy Solutions to use photographs of_____ (Print Name of Patient) for publication of any book, advertisement, pamphlet, electronic medium or other material which may be written, published, produced or copyrighted by them or parties of interest. I also release them from any claims and all liability for damages of every kind now existing or which may arise from the use of these photographs.

I HAVE READ AND UNDERSTAND THIS RELEASE.

_____ DATE

_____SIGNATURE OF PATIENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Advanced Therapy Solutions. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Advanced Therapy Solutions to release any of my protected healthcare information.

_____

Patient's or Authorized Representative's Printed Name & Date

_____

Patient's or Authorized Representative's Signature