ACHIEVE ORTHOPEDIC REHAB INSTITUTE

Patient Name:	Date of Birth
Patient Address	
Patient Phone:	Patient SSN:
Patient Email:	
Emergency Contact Name:	
Emergency Contact Phone:	
Primary & Secondary Insurance Name:	
Insurance Policy Holder Name:	Insurance Policy Holder DOB:
ONLY FOR WORKERS COMPENSATION	
Injury Date:	Claim Number:
WC Adjuster name:	Adjuster Phone#:
Employer Name:	State that injury happened:
Employer Address:	

Please Read and Initial the following	
I have informed Achieve Staff of any insurance coverage or changes that I am aware of.	______ **Initial**
I understand that as a courtesy Achieve Staff will be verifying my insurance benefits. However, I understand that a quote of benefits is not a guarantee of payment.	______ **Initial**
I understand that Co-Pays, Deductible and Co-Insurance specified by my insurance are my responsibility at the time of service. These fees are not negotiable.	______ **Initial**
I understand appointment cancellation and the No-Show policy includes failure to give 24 hours prior notice and will result in $75 fee. This fee can't be billed to your insurance company and will be your responsibility. This will be billed to your card on file.	______ **Initial**
I authorize Achieve Orthopedic Rehab to leave message/voicemail as needed	______ **Initial**

Print Patient Name:______________________________________ Date:__________

Patient Signature:____

Achieve Orthopedic Rehab Institute

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PATIENT CONSENT/AUTHORIZATION FORMS

o **CONSENT OF TREATMENT: I authorize Achieve Ortho Physical Therapist (s) to perform treatments including but not limited to Therapeutic Exercises, Pain treatment modalities (interferential, ultrasound, e-stimulation, ice/heat) and Manual Therapy.**

o **I also certify that no guarantee or assurance has been made as to the results that may be obtained. I have read and understand the above. I consent to participate in the Evaluation and treatment offered to me. I understand that I may stop treatment anytime.**

______ **Initial**

o **RELEASE OF MEDICAL RECORD: In order to ensure proper follow up and continuity of care, I agree that a copy of my Medical Record may be release to my referral Physician and/or my insurance company any information required in the course of my examination or treatment which is necessary to process claims for services rendered.**

o **I also authorize Achieve Orthopedic Rehab to discuss my medical condition with another person (spouse, care-taker, attorney, other)**

Please let us know whom you authorize: ___________________________________

______ **Initial**

o **INSURANCE AUTHORIZATION: I request that payment of authorized benefits be made to Achieve Ortho Rehab on my behalf for any services provided to me.**

o **I agree to pay for all my charges not covered. I authorize a copy of this authorization to be used in place of the original.**

______ **Initial**

o **CONSENT OF RELEASE AND USE OF CONFIDENTIAL INFORMATION: I have the right to examine and obtain a copy of my health records at any time. Should any Medical records be requested must be submitted in writing.**

______ **Initial**

o **We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them. Patients have the right to file a formal complaint about any possible violations of these policies and procedures.**

______ **Initial**

o **I understand that this consent is valid until it is revoked by me. I understand that I may revoke at any time by giving written notice of my desire to do so to the Physical Therapist. I also understand that I won't be able to revoke in cases where PT has already relied on it to use disclose my health information.**

______ **Initial**

o **I understand that Achieve Ortho Rehab has reserved the right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revise notice will be provided to me.**

______ **Initial**

IF THE PATIENT REFUSES TO INITIAL & SIGN THIS CONSENT FOR THE PURPOSE OF TREATMENT, ACHIEVE ORTHOPEDIC REHAB HAS THE RIGHT TO REFUSE CARE

Print Patient Name:____Date:_______________

Patient Signature:____

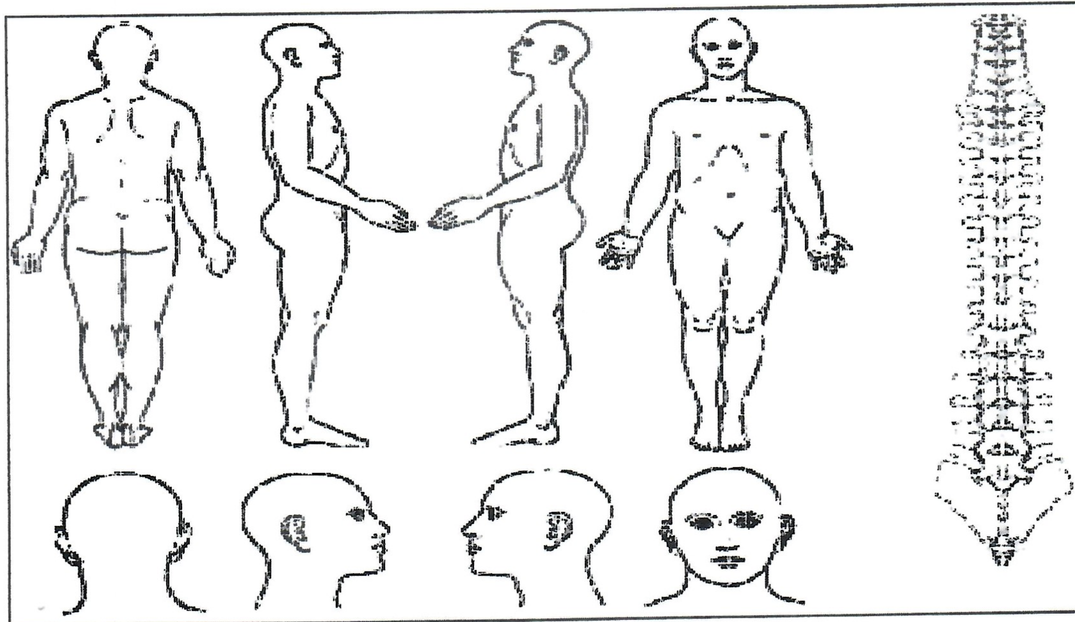
Achieve Orthopedic Rehab Institute

Patient Symptoms Report &Diagram

APTA American Physical Therapy Association The Science of Healing. The Art of Caring. CREDENTIALED RESIDENCY PROGRAM

Name: ______________________________ DOB: ____/____/______

Mark the drawing according to where you hurt (ex: if the back of your neck has pain, circle the back of the neck, etc.). If you feel any symptoms, please indicate where you feel them by placing marks on the diagram. Include all affected areas.



Please circle the appropriate number below showing how bad your pain is now: **HEIGHT**______ **WEIGHT**______

Now:	**No pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst possible pain**
At Worst:	**No pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst possible pain**
At Best:	**No pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst possible pain**

1. **What is the purpose of Today's Evaluation?**
2. **Are you still working?** ☐ **Yes** ☐ **No** if not when was the last day on the Job?
3. **Occupation:**
4. **When (roughly what date) did your present pain start?**
5. **How did symptoms start?** (Check appropriate box)

☐ No apparent cause ☐ Gradually ☐ Twisting ☐ Bending

☐ Lifting ☐ Fall ☐ Pulling /Pushing ☐ Suddenly

☐ **Injured during work**	☐ **Injured in auto accident**	☐ **Injured at sports**
Date: ____/____/______	**Date:** ____/____/______	**Date:** ____/____/______

6. **Have you had similar pain?** ☐ Yes ☐ No ☐ Date ____/____/______

7. **Have you been hospitalized for your pain problem?** ☐ Yes ☐ No Date ____/____/______

8. **How do you describe your pain?** ☐ Constant ☐ Intermittent

9. **What describes the nature of your symptoms?**

☐ **Sharp** ☐ **Shooting** ☐ **Burning**

☐ **Dull ache** ☐ **Numb** ☐ **Tingling**

Patient Symptoms Report &Diagram

10. What activities make the pain:

	Better	Worse	No Difference	Comments
□ Exercise				□ During □ After
□ Lying down				□supine □ right side □ left side
□ Sitting				□ How long
□ Standing				□ How long
□ Walking				□ Distance
□ Bending				□ forward / backward □ right side □ left side
□ Overhead activities				
□ Lifting / pushing / pulling				
□ Coughing / Sneezing				
□ Pain Medications				
□ Other				

11. What medications are you currently taking? (If additional space is needed please use the back of this sheet)

12. Have you received any of the following tests? Date:

□ Diagnostic x-rays □ CT (computed tomography) scan □ Electromyogram (EMG)
□ Discogram □ MRI (magnetic resonance imaging) □ Others ___________

13. In general would you say your overall health right now is...

□ Excellent □ Very good □ Good □ Fair □ Poor

14. Medical history (Circle Yes or No)

Allergies	Y / N	Dizzy Spells	Y / N	MRSA	Y / N
Anemia	Y / N	Emphysema/Bronchitis	Y / N	Multiple Sclerosis	Y / N
Anxiety	Y / N	Fibromyalgia	Y / N	Muscular Disease	Y / N
Arthritis	Y / N	Fractures	Y / N	Osteoporosis	Y / N
Asthma	Y / N	Gallbladder problems	Y / N	Parkinson's	Y / N
Autoimmune Disorder	Y / N	Headaches	Y / N	Rheumatoid Arthritis	Y / N
Cancer	Y / N	Hearing Impairment	Y / N	Seizures	Y / N
Cardiac Conditions	Y / N	Hepatitis	Y / N	Smoking	Y / N
Cardiac Pacemaker	Y / N	High Cholesterol	Y / N	Speech Problems	Y / N
Chemical Dependency	Y / N	High/Low Blood Pressure	Y / N	Strokes	Y / N
Circulation Problems	Y / N	HIV / AIDS	Y / N	Thyroid Disease	Y / N
Currently Pregnant	Y / N	Incontinence	Y / N	Tuberculosis	Y / N
Depression	Y / N	Kidney Problems	Y / N	Vision Problems	Y / N
Diabetes	Y / N	Metal Implants	Y / N	Other:	Y / N

15. Fall History:

□ Injury as a result of fall in the past year: Yes / No When:

□ Two or more falls in the past year: Yes / No When:

16. Surgical History:(If additional space is needed please use the back of this sheet)

□ Date:____/______/_______ □ Body region:

□ Surgery type:

17. Do you have any additional information that would be helpful in understanding your problem?

Patient signature: ____ **Date:** __________