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Physical, Sports and Hand Therapy

Name: _____ Date:_____

Leisure activities, including exercise routines:_____

Occupation, including activities that comprise your workday:_____

Age: _____ Height: _____ Weight:_____

Are you latex sensitive? ❑ YES ❑ NO Do you smoke? ❑ YES ❑ NO

Do you have a pacemaker? ❑ YES ❑ NO Do you have hearing loss? ❑ YES ❑ NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ❑ YES ❑ NO

ALLERGIES: List any medication(s) you are allergic to: _____

_____

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue
❑ fever/chills/sweats
❑ nausea/vomiting
❑ weight loss/gain
❑ constipation
❑ headaches
❑ difficulty maintaining balance while walking
❑ difficulty swallowing
❑ falls
❑ numbness or tingling
❑ muscle weakness
❑ dizziness/lightheadedness
❑ heartburn/indigestion
❑ fainting
❑ changes in bowel or bladder function
❑ diarrhea
❑ shortness of breath

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer
❑ heart problems
❑ chest pain/angina
❑ high blood pressure
❑ circulation problems
❑ blood clots
❑ stroke/ head injury
❑ anemia
❑ bone or joint infection
❑ chemical dependency (i.e., alcoholism)
❑ pelvic inflammatory disease
❑ depression
❑ lung problems
❑ tuberculosis
❑ asthma
❑ rheumatoid arthritis
❑ other arthritic condition
❑ bladder/urinary tract infection
❑ kidney problem/infection
❑ sexually transmitted disease/HIV
❑ pneumonia
❑ thyroid problems
❑ diabetes
❑ osteoporosis
❑ multiple sclerosis
❑ epilepsy
❑ eye problem/infection
❑ ulcers
❑ liver problems

During the past month have you been feeling down, depressed or hopeless? ❑ YES ❑ NO

During the past month have you been bothered by having little interest or pleasure in doing things?

❑ YES ❑ NO

Is this something with which you would like help? ❑ YES ❑ YES, BUT NOT TODAY ❑ NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ❑ YES ❑ NO

Pappas | OPT
Physical, Sports and Hand Therapy

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer
❑ heart problems
❑ high blood pressure
❑ diabetes
❑ stroke
❑ depression
❑ tuberculosis
❑ thyroid problems
❑ blood clots

Please list all medications you are currently taking: (including dosages and frequency):

-Blood Pressure Medication _____
-Heart Medication _____
-Anti-coagulants (blood thinners) _____
-Muscle Relaxants _____
-Pain Killers _____
-Diabetes Medication (i.e. insulin) _____
-Steroids _____
-Anti-inflammatories _____
-Other Medications (state condition) _____

Have you ever taken steroid medications for any medical conditions? ❑ YES ❑ NO
Have you ever taken blood thinning or anticoagulant medications for any medical conditions?
❑YES ❑NO
Please List all surgeries you have had (include dates): _____
What date (roughly) did your present symptoms start?_____
What do you think caused your symptoms? _____

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same

Treatment received so far for this problem (chiropractic, injections, etc)

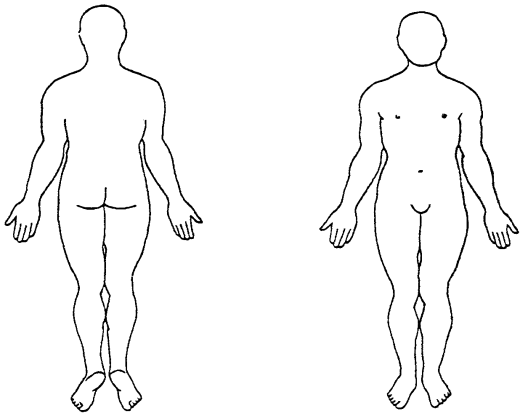
Please list special tests performed for this problem (x-ray, MRI, labs, etc)

Have you ever had this problem before: ❑ Yes ❑ No When_____ Treatment rec'd

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Aggravating Factors: Identify important positions or activities that make your symptoms worse:

_____

_____

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Easing Factors: Identify important positions or activities that make your symptoms better:

_____

_____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:
Your current level of pain while completing this survey: _____
The best your pain has been during the past 24 hours: _____
The worst your pain has been during the past 24 hours: _____

I certify that the above information is accurate to the best of my knowledge.

_____ _____
Patient Signature Date

Consent To Treatment

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.
2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility.
3. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.
4. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.
5. Worker's Compensation - I hereby authorize Pappas Physical and Hand Therapy to receive my records related to my work injury.

_____ _____
Patient Signature Date

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Photo/Video Authorization

I grant to Pappas Physical and Hand Therapy and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and\or videos of me in connection with my participation in physical/occupational therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization.

❑ Agree or ❑ Decline

Notice of Privacy Practices

By signing this form, I acknowledge that Pappas Physical and Hand Therapy has made its' Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with Pappas Physical and Hand Therapy Specialists representatives.

_____ _____

Patient Signature Date

PT/OT Benefits Provided by Your Insurance Company

I acknowledge that my physical therapy benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/or co-insurance. I acknowledge that I should contact a representative of Pappas Physical and Hand Therapy if I do not understand my benefits, have questions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment.

I understand that the information provided regarding my insurance is an estimate and a quote of benefits and may not reflect the exact balance owed. I acknowledge that I am responsible for any balance not covered by my insurance and that I have the right and responsibility to follow-up with my insurance for specific questions regarding my individual policy.

INITIAL VISIT WITH TREATMENT $_____
FOLLOW UP VISITS $_____
DEDUCTIBLE $_____

Communication: I authorize PPHT to communicate with me via email and/or Text message.

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❑YES ❑ NO

❑ EMAIL: _____
❑ PHONE: _____

Release of Information

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing:

Name:	Relationship:

Authorization

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive my health information.

_____ _____

Patient or Guardian Signature Date