WHOLE BODY HEALTH
PHYSICAL THERAPY

When updating information, please do not write 'same'

Please Print **Date:**

Name _____
First Last Preferred Name

Mailing Address _____
Street Apt # City State Zip

Please check the contact preference for you. E-mail is used for client updates and home exercise programs.

☐ Home Phone _____ ☐ Work Phone _____ ☐ Cell Phone _____

☐ E-Mail _____ Date of Birth _____ Age _____ Sex _____

Preferred Pronoun? _____ Occupation _____

Emergency Contact_____Relation _____ Phone _____

PCP and/or Referring Physician _____

Office name/address _____ Phone _____

*How did you hear about our clinic?

If patient is minor, indicate who is responsible for the bill

Name _____ Address _____

Home Phone _____ Employer _____

Work Phone _____ Birth date of Insured _____ Relationship to patient _____

Medical Insurance

1. Primary Insurance Company _____

Name of Insured _____ Date of Birth of Insured _____

Subscriber or ID# _____ Group# _____ Insurance Phone _____

2. Secondary Insurance Company _____Name of Insured:_____

Subscriber or ID# _____ Group# _____ Insurance Phone _____

Acknowledgement of Receipt of Notices of Privacy Practices

I, _____, have received or been offered a copy of this office's Notice of Privacy Practices.
(Please print name)

_____ _____
Signature **Date**

Release of Information for Research Purposes

_____ Please initial to agree to allow anonymous information to be released for research purposes only.

MEDICATIONS

Please list any supplements, prescription or over-the-counter medications that you are taking:

_____

_____

_____

FAMILY HISTORY

Indicate (M)mother (F)father (B)brother (S)sister have had:

___Arthritis ___Heart disease ___Psychological

___Cancer ___Hypertension ___Stroke

___Diabetes ___Osteoporosis ___Other

GENERAL HEALTH/LIFESTYLE HABITS

☐ Right handed ☐ Left Handed

My health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Life changes in the past year? ☐ Yes ☐ No

☐ I smoke:____ packs/day _____ cigars/pipes/day

☐ I stopped smoking in _____ (year)

☐ I average _____ alcoholic beverages/week

SOCIAL HISTORY

Have you completed an advanced directive? ☐ Y ☐ N

Are there any customs/religious beliefs that may impact your care? ☐ Yes ☐ No

Job title/duties:_____

Is this a ☐ full duty or ☐ light duty position?

☐ Currently out of work ☐ Retired ☐ Other

I am ☐ a full time or ☐ part-time student ☐ N/A

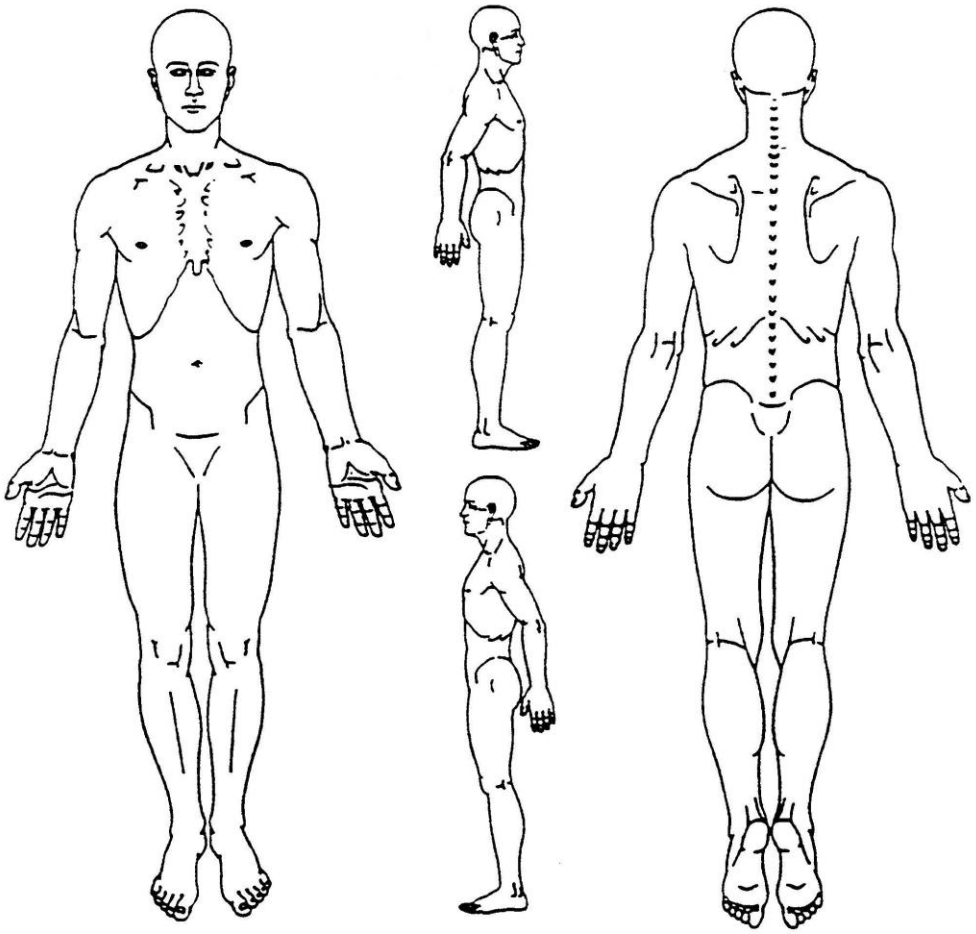
HEALTH CHANGES IN THE PAST YEAR

☐ Arm/leg numbness/ tingling
☐ Bladder problems/ changes
☐ Bowel problems/ changes
☐ Chest pain
☐ Coordination problems
☐ Cough
☐ Difficulty sleeping
☐ Difficulty swallowing
☐ Difficulty walking
☐ Dizziness/blackouts
☐ Fainting
☐ Fever/chills
☐ Hearing problems
☐ Heart Palpitations
☐ Hoarseness
☐ Joint pain or swelling
☐ Loss of appetite
☐ Loss of balance
☐ Memory issues
☐ Nausea/vomiting
☐ Other changes (hair loss, perspiration)
☐ Pain at night
☐ Reproductive health issues
☐ Ringing in ears
☐ Oral sensation changes
☐ Shortness of breath
☐ Vision problems
☐ Unexplained weight changes
☐ Other(explain):

PAST MEDICAL HISTORY

☐ Allergies
☐ Anxiety
☐ Arthritis
☐ Balance Disorders
☐ Broken bones/ fractures
☐ Cancer
☐ Depression
☐ Development/growth problems
☐ Diabetes
☐ Epilepsy/seizures
☐ Fibromyalgia
☐ Head injury
☐ Headaches/migraines
☐ Heart problems
☐ Hepatitis
☐ High cholesterol
☐ High blood pressure
☐ Infectious disease (ex. TB)
☐ Kidney problems
☐ Low blood sugar
☐ Lung problems
☐ Multiple sclerosis
☐ Muscular dystrophy
☐ Neurological
☐ Osteoporosis
☐ Parkinson's Disease
☐ Pneumonia
☐ Motor Vehicle Accident(s)
☐ Repeated infections
☐ Skin diseases
☐ Sleep apnea
☐ Sprain or strain
☐ Stroke
☐ Thyroid problems
☐ Trauma
☐ Ulcer/stomach problems
☐ Whiplash
☐ Other:

Draw the location of your pain on the figures to the right using the following symbols:	
Ache	^ ^ ^ ^ ^ ^
Numbness	O O O O O
Pins and Needles	• • • • • •
Burning	= = = = = =
Stabbing	/ / / / / / /
Other	X X X X X X



CURRENT CONDITIONS/CHIEF COMPLAINT(S)

_____

Please describe your problem

Does anything make the problem(s) better?

Does anything make the problem(s) worse?

Date when current episode began:_____

Any clinic tests in the past year? ☐ Yes ☐ No

Any surgery in the past year? ☐ Yes ☐ No

PATIENT SPECIFIC FUNCTIONAL SCALE

Below, please identify up to three important activities that you are unable to do or are having difficulty with as a result of your current condition

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity — Able to perform activity at same level before problem

Activity: Score:

1._____ _____

2._____ _____

3._____ _____

Cancellation Procedure- It is the policy of WBHPT that we require timely notification of all cancellations. If a client cancels less than 24 hours prior to the appointment, *we reserve the right to charge a **$35.00 fee***. We also *reserve the right to charge **$75.00** for a no show to an appointment*. No show charges must be made current before scheduling another appointment. After 3 no shows or less-than-24-hour cancellations in a 12 month period, it is at the discretion of WBHPT whether we continue to allow appointments to be scheduled or we discharge the client from the clinic.

Financial Responsibility- Clients are responsible for all charges for the treatment provided by Whole Body Health Physical Therapy (WBHPT). As a courtesy, we bill most insurances directly. However, primary responsibility for the account is yours. Payment is due within 30 days of the first billing unless other financial arrangements have been made. Established clients with a delinquent balance will be asked for payment at the time of service. Cash paying client payments are due at the time of service unless prior arrangements have been made with our office administrator.

Financial Agreement- The undersigned agrees that in consideration of services to be rendered, you assume financial responsibility for this account under the terms and conditions listed above. Persistently delinquent accounts will be referred to an independent collection agency or small claims court, in which case you will assume full responsibility for collection costs, including attorney and/or court fees.

Insurance Billing- Providing correct insurance billing information is the responsibility of the client. If your insurance changes, ***please present your new card*.** If billing information is incomplete, the services will be billed directly to you. Thus, you will be responsible for payment even though you may have insurance, which may have covered services, but denied payment due to incomplete information. Insurance co-pays are due at time of service.

Authorization to Leave Private Information on voice mail/or email- I authorize WBHPT and/or staff to leave a message regarding my medical, billing, appointment, or scheduling information on an answering machine and/or voice messaging system and/or email provided by the client unless otherwise noted.

Authorization to Release Information/Assignment of Insurance Benefits- I/we hereby authorize the insurers named on the front of this agreement to pay directly to WBHPT in accordance with the billing, any benefits that may apply under their policies, and hereby irrevocably assign such benefits to WBHPT to the extent of such billing. I/we hereby authorize the release of any and all medical information requested by any insurer in connection with processing any request for benefits to which I may be entitled, and WBHPT to make such requests on my behalf. I understand that information protected by state and federal law may be requested, and I specifically consent to the release of such protected information in relation to the care provided.

Motor Vehicle Accident- If you are receiving treatment as a result of an MVA you are responsible for any cost of treatment not reimbursed by the your Personal Injury Protection (PIP) auto insurance coverage. If your PIP expires or exhausts it is your responsibility to provide us with your medical insurance (MI) information if you would like us to bill them on your behalf. If you have MI, we suggest you provide that at your first MVA visit so it is on record.

Workers Compensation (WC)- If your claim is denied or is in dispute, we will bill your regular medical insurance carrier pursuant to ORS 656.313. You will not be expected to pay for treatment, unless your claim is ultimately resolved against you. In order to file a WC claim, we will need the name of your insurance carrier, the date of injury, and claim number, if available. Be sure to notify the registration desk at each appointment if your visit is due to an injury covered by WC. Due to legislative rules, we are required to file our claims to your adjustor within 7 days of our Initial evaluation, thus we need a physicians order and authorization prior to initial treatment.

I have read and understand the above credit and release of information policies.

_____

Patients Printed Name

_____

Patient signature (parent or guardian if patient is a minor) Date