

Health Risk Questionnaire

Name _____ Age _____ Weight _____ Height _____

Please explain "Yes" answers in the spaces provided.

Yes No

Do you have heart trouble? _____

Do you have high blood pressure? _____

Has a member of your family had a heart trouble/stroke before age 60? _____

Do you have diabetes? _____

Do you smoke/chew tobacco? _____

Do you have asthma, bronchitis, emphysema? _____

Have you had rheumatic fever or tuberculosis? _____

Do you experience sudden, unexplained shortness of breath? _____

Do you experience sudden, unexplained rapid heartbeats? _____

Do you a disabling bone or joint disease (ex. Arthritis)? _____

Are you taking any medication (please list)? _____

Have you recovered from any acute illness or viral infection? _____

Has a medical doctor informed you to not participate in exercise? _____

Have you had an operation of any kind? _____

Have you recently had a checkup from your doctor? _____

Is there any other health information we should know that may affect your treatment? _____

Females: are you pregnant? (Please circle) YES NO

Other than my reason for being here today, I am in good health _____

I understand that if my medical condition, allergies or medication change, I need to inform the CPT staff.
Medications particularly, may influence the way you feel.

Signature: _____

Print: _____

Date: _____

Welcome to Charleston Physical Therapy

New Patient Registration

Date _____

Name _____
LAST FIRST MI

Address _____
CITY STATE ZIP

Personal Info _____
M/F DOB SSN MARITAL STATUS

Contact Info _____
HOME # CELL# EMAIL (for follow-up purposes)

Employer _____ Occupation _____ Work# _____

Emergency Contact _____
NAME & RELATIONSHIP (not in same home) PHONE

Name of person we can release information to and their relationship to patient:

(Billing, Appointments, Records) _____
NAME RELATIONSHIP PHONE

Who Referred You to CPT? Friend/Family _____ Physician _____

Area of Injury _____ Injury Date _____

This year: Have you had home health? _____ Or therapy in another clinic? _____

Physician Name _____ Have You Seen Them for this Injury _____

Who is to be Billed: (mark with X) Private Insurance _____ Self _____

Work Comp _____ Claim# _____ Auto/Accident Insurance _____ Claim# _____

Insurance Company Name _____ Member ID _____

Primary Card Holder _____
NAME SSN DOB

Relationship to Patient: (please circle) SELF SPOUSE PARENT OTHER _____

Secondary Insurance Name _____ Member ID _____

Secondary Card Holder _____
NAME SSN DOB

Relationship to Patient: (please circle) SELF SPOUSE PARENT OTHER _____

**CONSENT FOR TREATMENT
GUARANTEE OF ACCOUNT AND ASSIGNMENT OF INSURANCE BENEFITS**

CONSENT is hereby given to Charleston Physical Therapy Specialists (CPT) and the Physical Therapists, Occupational Therapists and Physical Therapy Assistants taking care of me to administer such therapeutic procedures that are deemed necessary on an outpatient physical therapy basis. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the result of evaluation and treatment either in the clinic or as a result of my home practice. I understand that there is a risk involved with any physical therapy or therapeutic program, such as: increased soreness, fractures, heart attack pain and death.

INITIAL

FURTHERMORE, I accept responsibility for payment of all charges and fees for all outpatient treatment services provided. I further authorize that any insurance benefits that are reimbursable for such service be paid directly to CPT and consent to the release of any medical information that may be required to verify the justness of any claim made as a result of this outpatient therapy and payment thereof. I understand that CPT will bill my insurance carrier on my behalf for all charges incurred; however, I agree that I am responsible for the full amount of my account (with the exception of certain government insurance plans).

DATE SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

1. I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to or obtain from the Social Security Administrator or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physical therapist or organization furnishing the services or authorize such physical therapist or organization to submit a claim to Medicare for payment to me.

INITIAL

1. Acknowledgment of receipt of statement of my rights while I am a Medicare patient.

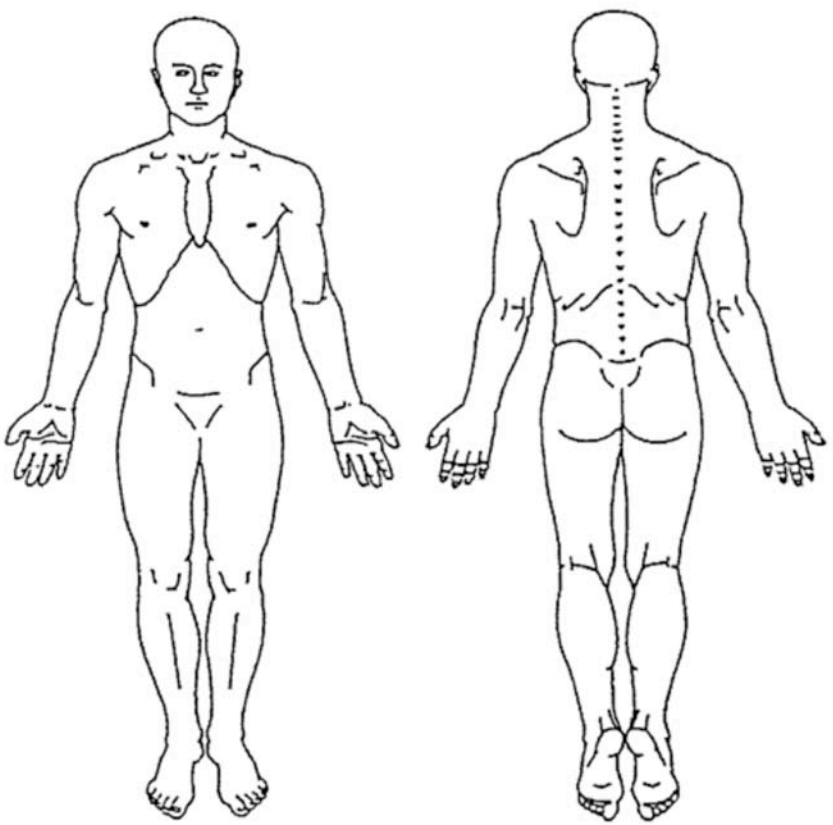
INITIAL

1. This is to acknowledge that I received a copy of CPT's Notice of Privacy Practices as required by HIPPA.

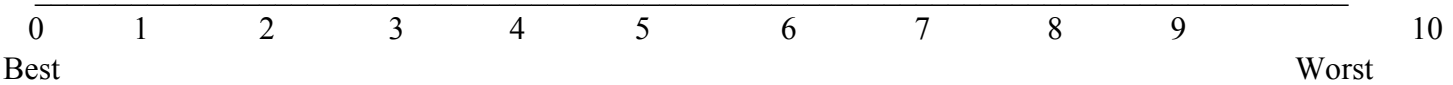
INITIAL

Name _____ DOB ____/____/____

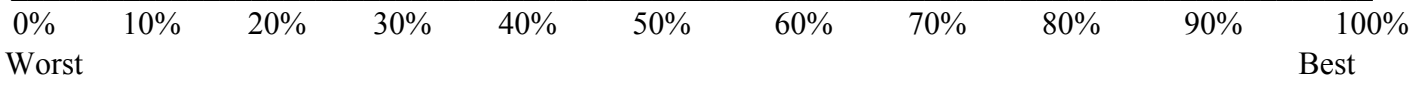
On the body diagram below, shade in the area(s) where you are having pain, tingling or numbness with this episode.



On the 0 - 10 scale provided below, circle the average pain level for this episode.



On the 0% - 100% scale provided below, circle the percent of normal function at which you are currently able to perform. This includes; work performance, activities at home, sports and socially with friends.



Current Medications _____

