FAST TRACK
Physical Therapy

Patient Information Form

Last Name_____ First Name_____ Middle_____
Address_____ City/State_____ Zip_____
Home Phone_____ Cell Phone_____ WorkPhone_____
Date of Birth_____ SSN_____ Email Address_____
Employer_____ Marital Status_____

Spouse's Name_____ Work Phone_____ DOB_____
Nearest Friend/Relative not living with you_____ Phone_____

Physician_____ Phone_____
Whom may we thank for referring you to us?_____

Insurance Company_____ Secondary Ins. Co._____
Policy No_____ Policy No_____
Group No_____ Group No_____

Workmans Comp Claim? Yes__ No__ If Yes, date of injury_____
Insurance Co_____ Adjuster Name_____ Claim #_____
Phone_____ Fax No_____ Address_____ DOI_____

Auto Accident? Yes__ No__
Have you been seen for PT/OT or Chiropractor during the calendar year? Yes__ No__
Why did you choose Fast Track Therapy for your therapy services?_____

Who is responsible party? / Legal guardian if a minor?_____
Date of Birth:_____ Phone No:_____ SSN:_____
Address:_____ Will be paying today by: Cash__ Check__ CC__

Please provide proof of insurance coverage upon completion of this form.
Assignment and Authorization: I authorize the release of any medical information necessary to process insurance/Medicare claims on my behalf. I authorize payment of medical benefits directly to **Fast Track Therapy** for services and supplies provided to me. A copy of this authorization shall be considered as a valid as the original and valid for the duration of my care. I understand I am eligible for all charges incurred should my insurance not pay for these services (Except for Workers Comp.)

Signature _____ Date _____

Name:_____**Date**:_____ **Referring Dr**._____**Next Follow Up Apt?**_____

1. **What is your main complaint or problem?**_____

Date of onset_____ **How did it occur**_____

_____

Age:_____**Height:**_____**Weight:**_____**(Medicare Required)**

2. **Do you have a history of falls or have fallen in the past year?** Yes:____ No:____ If yes did it result in injury? Yes:___ No___

3. **Please rate the level of your pain at its best and worst.**

0 1 2 3 4 5 6 7 8 9 10
No pain----------Extreme Agony

4**. What medications are you taking for this problem? Please list the names of the medications**:
Anti-inflammatory Pain killer Muscle relaxer Other_____

5. **List of other medications you are currently taking**:_____

6. **Date of surgery** (if applicable)_____Type_____

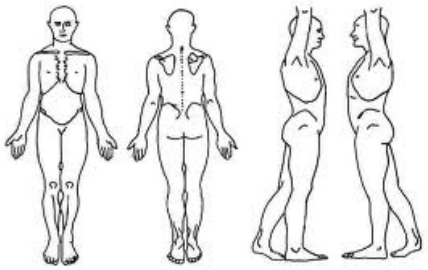
7. **If you have pain, please circle those words which best describe it.**
Constant Intermittent Sharp Dull Burning Throbbing Twinge Ache Numb Tingle Tight Pulling

8. **How do you feel in the: Morning?** *Better/worse* **Afternoon*?*** *Better/worse* **Evening*?*** *Better/worse* **Night?** *Better/worse*

9. **What positions or activities make your pain better?**_____
_____

10. **What positions or activities make you pain worse?**_____
_____

11. **Please indicate painful areas by shading models**.



12**. What tests/or treatment have you had for this problem? What were the findings? Previous Therapy?**
X-ray MRI CT Scan Myelogram EMG Other

13. **What is your occupation?**_____
a) Working *Full time Part time Light duty Not working*
b) Physical work requirements: *sedentary ight moderate heavy ery heavy*
c) Job requires prolonged: *sitting standing bending walking lifting squatting driving*

14**. What functional activities are you currently having problems with?**
Dress/bathe job duties housework cook/eat walk stand sit drive sleep recreation

15. **Do you have any medical problems**?_____ Pregnant?_____

16. **What do you hope to accomplish with physical therapy?**_____

17. **Medical History?**_____

FAST TRACK Physical Therapy

Welcome to Our Office

We are pleased that you have chosen Fast Track Physical Therapy for your outpatient Physical and Occupational Therapy services. This information answers some of the most commonly asked questions about our services. Feel free to ask any additional questions.

Payment For Services: As a courtesy to you, we will obtain authorization and bill your insurance company. **Please note:** All insurance co-pays and co-ins. are expected at the time services are rendered. **It is the patient's responsibility to know their insurance plan and coverage.**

Reposts to Physicians: We send a summary of your initial visit to your doctor. Please let us know 5-7 days in advance of future doctor appointments so we can send a letter informing them of your progress. Your written consent will be required to release medical records to anyone other than your physician and insurance company.

Hours of Operation: 7:00 am-7:00 pm Monday- Thursday, 7:00am-6:00 pm Fridays

Team Approach: Occasionally you may see a different Physical Therapist or Physical Therapist Assistant. This can offer new perspectives in treating your condition and enhance your progress. Your program and the services provided may change in response to your progress and needs. It is important that you do your hoe exercise program to improve your rate of progress. We look forward to working with you.

Regarding Appointment: Appointment times range from 60 to 90 minutes. Our facility remains very busy, especially the early morning and late afternoon appointments. It is important for you to attend your appointments regularly. Inconsistency in receiving your therapy treatments can adversely affect your progress and outcome. Patients that consistently cancel or no-show appointments will be discharged and their doctor will be notified of the reason of discharge. **Punctuality** is appreciated so you can receive the maximum benefit from your appointment. Our staff does their best to be on time.

Cancellation Policy: Because your attendance to physical therapy is the determining factor regarding your outcome, we take this subject seriously. Your referring physician and your therapist have prescribed a frequency or number of visits desired to have good results from therapy. We want you to achieve your goals.

- We require a **24-hour notice** in the event of a cancellation. We will do our best to reschedule you so that you do not miss any treatments to ensure you get the most benefit from therapy.
- We understand patients are coming in 2-3 times per week and things come up un-expectantly. If you are consistently canceling or no-showing without notice without 24 hour notice we will charge a **$25 late fee** assessed to the patient account. This will be your responsibility we do not charge this to insurance.
- For worker's compensation and personal injury patients, documentation of any missed appointments will be forwarded to your case manager.

I will allow Fast Track Physical Therapy to use my testimonials. Yes___ No___
I will allow Fast Track Physical Therapy to use my photos for publication. Yes___ No___

I have received a copy of the Outpatient Guidelines and Privacy Practice HIPPA form, and I consent to treatment by the Fast Track Therapy staff.

Signature:_____Parent or Guardian:_____Date:_____