

Welcome to Total Function Physical Therapy, PC!

We would like to thank you for choosing Total Function Physical Therapy, PC. We want to assure that your experience with us will be a pleasant one. Here is some of what you can expect on your first visit:

- Please arrive early on your first visit so that we may obtain copies of necessary insurance information.
- Please dress appropriately for your physical therapy sessions. We require that you wear comfortable clothing when you come to your appointments. Any type of loose clothing is suitable. Sweatshirts, sweatpants, shorts, and t-shirts usually work well. Dresses, denim, jeans and any tight clothing are not recommended.
- Expect to spend approximately one hour at our clinic for your first visit. After that, your appointments will be approximately 45 minutes in duration.
- Our office has a 24 hour cancellation policy. You must call 24 hours before your appointment time if cancellation is necessary; otherwise a \$25.00 fee will be billed to you and is to be paid before your next visit.
- If you have any special needs, questions, or concerns about your initial visit, please do not hesitate to contact us and we will be more than happy to assist you.

Financial and Information Release

Payment is expected at the time of service, insurance co-payments are mandated by your insurance company and **MUST** be made today. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I understand that a third party billing office will be handling my claim and will provide a breakdown of what the insurance is scheduled to pay as a courtesy to me. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount of services provided. I understand that the definition of “non-covered” is made by my insurance company.

I agree to Total Function Physical Therapy’s cancellation policy and agree to give 24 hr notice of cancellation or be charged a \$25.00 “no show” fee.

I request that payment of authorized insurance / Medicare benefits be payable to Total Function Physical Therapy, (FEIN 75-3138902) on my behalf for services furnished to me. In the event that my account is turned over to a collection agency or an attorney, I agree to pay all reasonable costs of collection and understand that I am no longer a patient at this office. I understand and agree to a return check charge of \$30.00 per returned check for any reason.

I authorize any holder of medical information about me to release any and all information to the healthcare financing administration, its agents, or my insurance carrier as needed to determine these benefits or the benefits for myself or my dependants. If I have health insurance coverage and it is requested by my physician, I authorize Total Function Physical Therapy to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

Print name of patient

Signature of patient or guardian

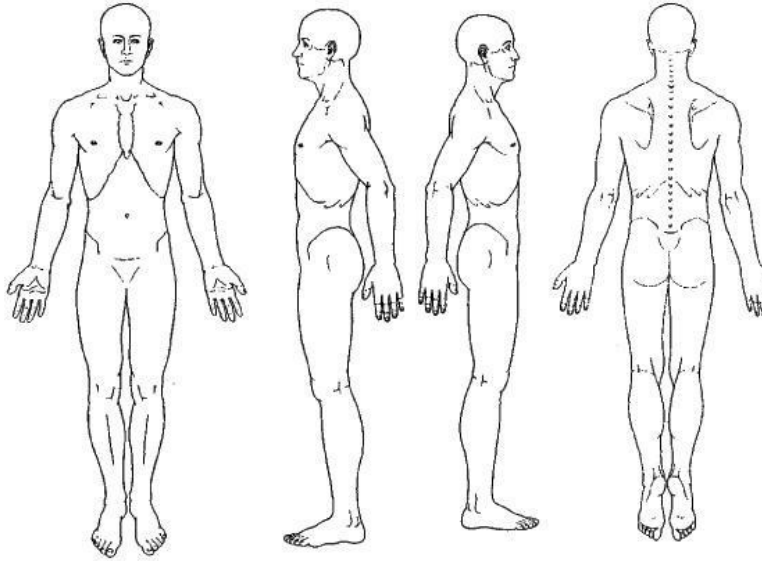
Date

Name _____

Date _____

Present Condition – Pain or Symptoms

- Please shade in area or areas where you are experiencing pain/symptoms. Then use the following descriptions of pain to indicate the type of pain in each area that you shade by drawing an arrow from each specific type of pain to the area you have shaded. Feel free to use more than one description for each shaded area.



- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> Severe | <input type="checkbox"/> Sharp | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Dull | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Burning | <input type="checkbox"/> Radiating (indicate direction) |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Other _____ |

- Please list each symptom that you are experiencing and rate each on a scale of 0-10 (10 being the most severe pain/symptoms you have ever experienced)

Symptoms

Severity

- | | |
|----------|------------------------|
| a. _____ | 0 1 2 3 4 5 6 7 8 9 10 |
| b. _____ | 0 1 2 3 4 5 6 7 8 9 10 |
| c. _____ | 0 1 2 3 4 5 6 7 8 9 10 |

- Since the initiation, has the pain changed? _____

- Have your symptoms: become worse become better remained the same

- How often do you experience the pain/symptoms? _____

- When and what do you think initially cause your pain/symptoms? Why? _____

Name: _____ Date: _____

7. What makes your symptoms worse?

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Other (please specify below) |
| <input type="checkbox"/> Bending | _____ |

8. What eases your symptoms? _____

9. How much does your pain interfere with your activities?

	DAILY	EXTRA-CURRICULAR
<input type="checkbox"/> None (1-20%)	_____ %	_____ %
<input type="checkbox"/> Rarely (20-40%)	_____ %	_____ %
<input type="checkbox"/> Often (40-60%)	_____ %	_____ %
<input type="checkbox"/> Most of the time (60-80%)	_____ %	_____ %
<input type="checkbox"/> Always (80-100%)	_____ %	_____ %

10. Are you taking any medications? Yes No

a. If yes, what and how much? _____

Past History of Symptoms

1. Have you ever had these kinds of symptoms before? Yes No

If yes, when? _____

2. How often have they recurred? _____

3. Has the frequency or severity of these symptoms increased since the last time?

Frequency Yes No Severity Yes No _____

Past Medical History

1. Accidents or Injuries? _____

2. Surgeries? _____

3. Other problems that have been diagnosed by a Physician? _____

4. Are you currently under the care of a physician or other health care provider other than the one who prescribed your Physical Therapy? Yes No

If yes, who? _____

5. Have you ever had Physical Therapy or body work previous to this occasion? Yes No

If yes, when and how much? _____

What are your goals in coming here? _____

How much time in a day are you willing to spend to get better? _____

Name: _____ Date: _____

Past and Present Medical Illnesses

Please mark any of the following that you have or had at one time:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Nervous system disease | <input type="checkbox"/> Positive HIV | <input type="checkbox"/> Seizures | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcers | | |

Please explain _____

Review of symptoms

Please mark any of the following with which you have ever had a problem:

- | | | |
|---|--|--|
| <input type="checkbox"/> Blacking out | <input type="checkbox"/> Blurring vision | <input type="checkbox"/> Bruise or bleed easily |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Change in weight | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Difficulty with balance |
| <input type="checkbox"/> Difficulty with coordination | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Memory Deficits | <input type="checkbox"/> Muscle pain or cramps | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Numbness or Tingling | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Speech/Communication | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Tremors | <input type="checkbox"/> Visual difficulty |

Equipment and devices

Please mark any of the following with which you have ever used:

- | | | |
|------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Brace | <input type="checkbox"/> Cane | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Glasses or contacts | <input type="checkbox"/> Hearing aid |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Walker | |

For women only

- Are you pregnant? Yes No
- Do you have a regular, normal menstrual cycle? Yes No
- Do you have considerable pain or discomfort during your period? Yes No
- Do you have a DNR (do not resuscitate) in place? Yes No

If yes, please provide us a copy for your file.

TOTAL FUNCTION

Physical Therapy PC

HIPPA RELEASE FORM

I hereby authorize use of disclosure of protected health information about me as described below:

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure: any and all physicians, hospitals, clinics or medical care providers.
2. The following person or class of persons may receive disclosure of protected health information about me: any representative of Total Function Physical Therapy PC, 502 East Pike's Peak Avenue, Colorado Springs, CO 80903.
3. The specific information that should be disclosed is: any and all medical records, medical history forms, pain diagrams, narrative reports, treatment notes, transcript of radiologic reports, psychiatric or psychological records, or other documentation, including medical bills, statements for medical services rendered, pertaining to the person who has signed this authorization.
4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying all health care providers in writing of my desire to revoke it. However, I understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition treatment of me whether or not I sign the authorization.
6. This authorization expires in two (2) years, OR upon occurrence of the following event that relates to me or to the purpose of the intended use of discloser of information about me.
7. A copy or fax of this authorization will be valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee will be charged for copies of my medical records.

Print name of patient

Signature of patient or guardian

Date