PATIENT INFORMATION ACCT#________________

SOCIAL SECURITY #________________________ DRIVER'S LICENSE#________________________

☐ MARRIED ☐ SINGLE ☐ WIDOW ☐ DIVORCED

NAME ____ BIRTHDATE____- ____-____ AGE______SEX_____
Last First MI

HOME ADDRESS_____________________________________CITY________________STATE_______ZIP_________

BILLING ADDRESS___________________________________CITY________________STATE_______ZIP_________

PHONE HOME( )______________________________ MOBILE( )_________________________________

EMPLOYER____OCCUPATION___________________________

WORK PHONE ( )______________________EMAIL:____

EMERGENCY CONTACT____PHONE( )________________________
Last First MI

REFERRING PHYSICIAN

LAST SEEN MD____-___-_____ UPIN________________ NPI____

REFERRING PHYSICIAN____ PHONE( )_________________________

DIAGNOSIS____ICD 9 CODE____________________**DOI**____-____-_____

Do you currently or have you in the past 6 months had home healthcare services? ☐ Yes ☐ No

Have you been hospitalized in the past 60 days? ☐ Yes ☐ No

If yes to either question, who is your home health provider? ______________________________________

What is the discharge date for your hospitalization/home healthcare services? ___________________________

MEDICAL INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD(S)
Please provide Name of Insured and Birthdate for all plans.

☐ SELF ☐ PRIVATE ☐ AUTO ☐ LIEN ☐ MEDICARE ☐ WORK COMP ☐ OTHER ___________

INSURANCE____GROUP#_______________ID#________________________

NAME OF INSURED____BIRTHDATE____/____/____SEX___________

WORKERS' COMPENSATION INFORMATION DOI_____-_____-_____

ADJUSTOR__________________________________CLAIM#_____________________________PHONE( )___________

AUTHORIZED BY_____________________________DATE__________________**DURATION**______________________

ATTORNEY__________________________ADDRESS____________________________PHONE( )_________________

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

NAME____ SOCIAL SECURITY #___________________
Last First MI

RELATIONSHIOP TO THE PATIENT___________________________________BIRTHDATE ___/___/___SEX_______

ADDRESS____HOME PHONE ( )__________________

EMPLOYER____ OCCUPATION__________________________

ADDRESS____WORK PHONE ( )__________________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider of medical services and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

PLEASE READ AND SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to ***CENTRAL COAST PHYSICAL THERAPY*** and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize ***CCPT*** to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE____**DATE**_____________________________

Central Coast Physical Therapy

PAST MEDICAL HISTORY:

Please circle any condition that you currently have or have had in the past:

High blood pressure	Stroke	Arthritis
Lung Disease/Problems	Cancer	Kidney Disease
Heart Disease/Problems	Diabetes	Liver Disease
Asthma/Allergies	Pacemaker	Angina
Circulation/Bleeding Problems	Osteoporosis	Fibromyalgia

Are you allergic to latex?	YES	NO
Do you Smoke?	YES	NO
Are you Pregnant?	YES	NO

During the past month have you often been bothered by feeling down, depressed, or hopeless? YES NO
During the past month have you often been bothered by little interest or pleasure in doing things? YES NO

Are you currently taking any medications? YES NO
If yes, please list ALL medications you are currently taking:

____

____

____

Please list past surgeries and dates:

____

____

____

Please list any medical conditions you have that have not been documented above:

____

____

What are your physical therapy and/or fitness goals?:

____

____

Patient signature:____**Date:**______________________

Central Coast Physical Therapy

Medical Screening Form

Name____Date:_______________

CURRENT CONDITION:

When did these symptoms start?____

How did the injury occur?: (gradually, suddenly, injury):____

My symptoms are currently: getting better / about the same / getting worse

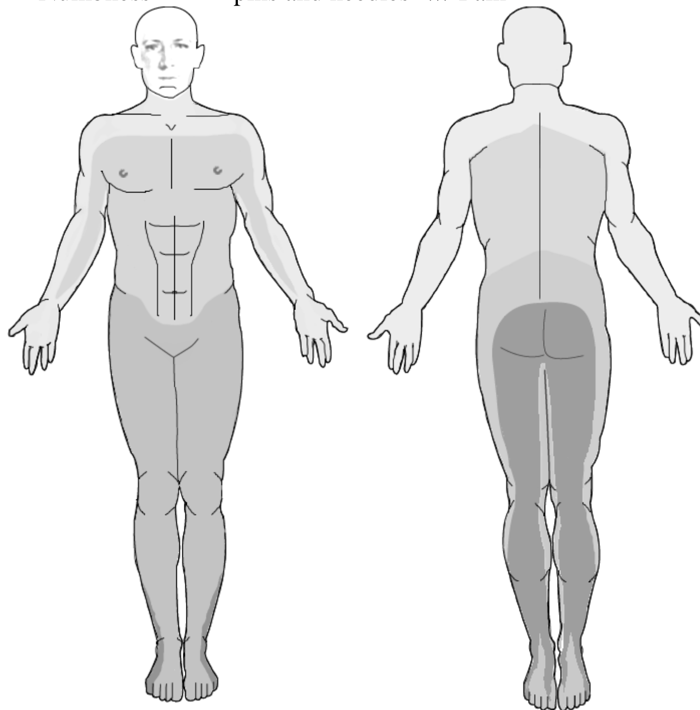
Please list any previous treatment for the condition we are seeing you for today:________________________________

Have you ever had this problem before? YES NO

If so how was the problem treated?____

Have you had any imaging studies done for this problem (x-rays, MRI, etc.) YES NO

Please use the following symbols: ^^^ Numbness *** pins and needles /// Pain



Rate your pain (1=mile, 10=severe): At its worst: 1 2 3 4 5 6 7 8 9 10 At its best: 1 2 3 4 5 6 7 8 9 10
Right now: 1 2 3 4 5 6 7 8 9 10

<u>Currently I am experiencing the following (circle all that apply):</u> dizziness

Unexplained weight loss	difficulty swallowing	changes in bowel or bladder function
Increased pain at night	headaches	depression
Fever/chills/sweats	nausea/vomiting	shortness of breath
Changes in appetite	numbness or tingling	poor balance/falls

Central Coast Physical Therapy

7380 Morro Rd., Atascadero, CA., 93422

Ph: 805-462-1110 Fax: 805-462-0660

OFFICE POLICY

Consent To Treatment: I the undersigned agree to give my consent to Central Coast Physical Therapy to furnish physical therapy care and treatment services. These services include but are not limited to therapeutic test/s, treatments or procedures, manipulation, stretching, or exercise as directed under the general instructions of the Physical Therapist, Physical Therapist Assistant, or Physical Therapy Aide. I authorize my Physical Therapist(s) to take photographs relating to my physical condition as are deemed necessary.

Consent for treatment of a Minor: As parent and/or legal guardian, I authorize Central Coast Physical Therapy to treat

____(minors name) while I am not present.

Assignment of Insurance Benefits: I hereby authorize Central Coast Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Workers Compensation Claims: If you claim workers compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

Cancellation and No-Show Policy: Central Coast Physical Therapy requires a 24 hour notice in the event of a cancellation. The charge for cancellation or no-show without proper notice is $25. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

Co-Payments: Co-payments may be paid at the time of service. If your co-payment is not paid at the time of service you will be billed for your contracted co-payment.

Non-Sufficient Funds: Checks returned for non-sufficient funds may be subject to a $25 processing fee.

____ ______________________

Patient/Guardian/Responsible Party Signature Date

____

Print Name

Financial Policy: We will gladly bill your insurance company directly. Your contract for health insurance is between you and your insurance company. We are not party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and Central Coast Physical Therapy. It is ultimately your responsibility to see that your physical therapy bill is paid in full. If formal collections procedures become necessary you will be responsible for additional costs incurred. Furthermore, I understand that I cannot change my chosen payment option after services have been rendered .

☐ I choose to self-pay at a discounted cash rate. I further understand that no insurance company will be billed and that I cannot change from this option during my course of treatment.___________________(please initial).

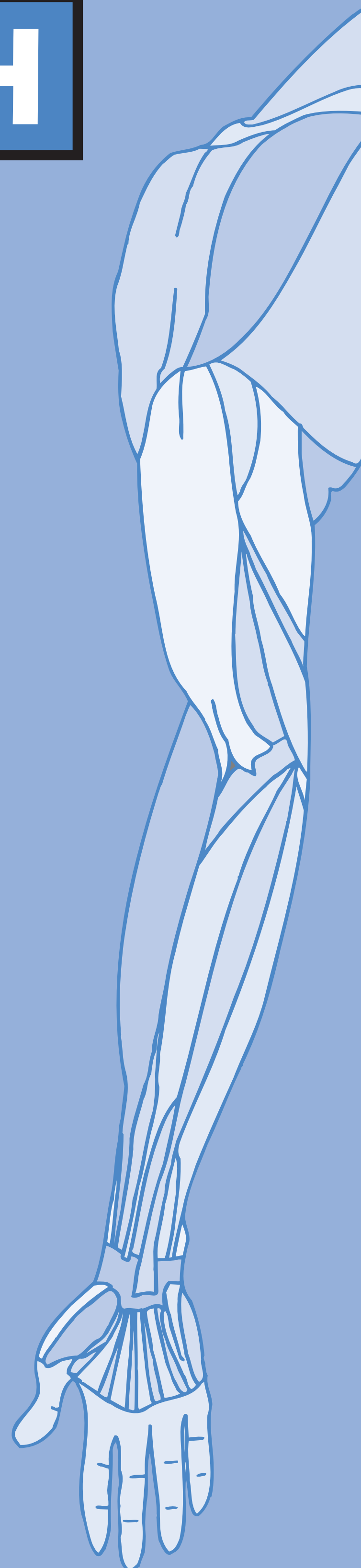
☐ I choose to have Central Coast Physical Therapy bill my insurance company. It is my responsibility to understand my physical therapy benefits and coverage.________________________(please initial).

The above financial information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

____ __________________________

Patient/Guardian/Responsible Party Signature Date

THE DASH



INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

DISABILITIES OF THE ARM, SHOULDER AND HAND

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

DISABILITIES OF THE ARM, SHOULDER AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = $\left[\left(\frac{\text{sum of n responses}}{n}\right) - 1\right] \times 25$, where n is equal to the number of completed responses.

A DASH score may not be calculated if there are greater than 3 missing items.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:____________________________

p I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*.
If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_

o I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may not be calculated if there are any missing items.

INSTITUTE FOR WORK & HEALTH
INSTITUT DE RECHERCHE SUR LE TRAVAIL ET LA SANTÉ

© INSTITUTE FOR WORK & HEALTH 2006. ALL RIGHTS RESERVED