

**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  NoHave 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

RELATIONSHIP 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:**

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**Please list past surgeries and dates:**

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

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

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Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Central Coast Physical Therapy

## Medical Screening Form

Name \_\_\_\_\_ Date: \_\_\_\_\_

### CURRENT CONDITION:

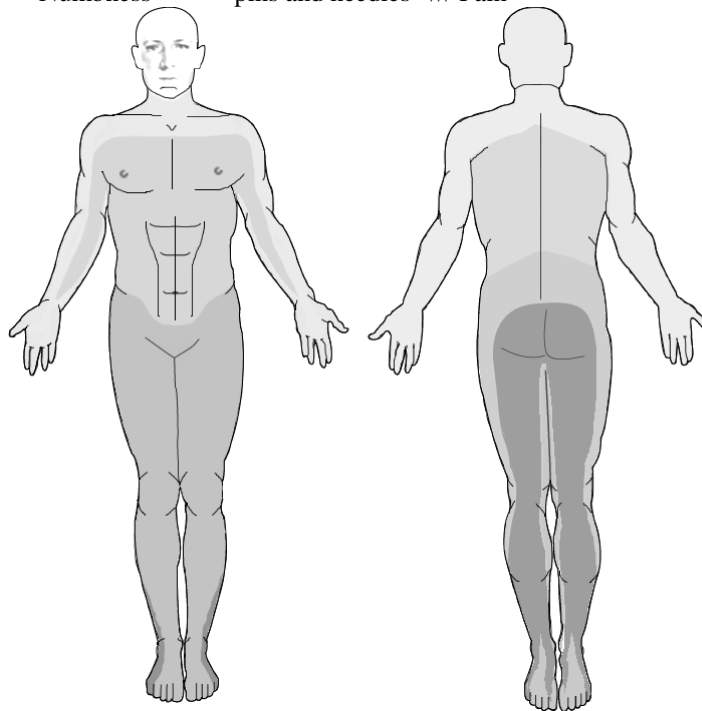
When did these symptoms start? \_\_\_\_\_

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=mild, 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

**Currently I am experiencing the following (circle all that apply):** 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 LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	<b>Column Totals:</b>					

**Minimum Level of Detectable Change (90% Confidence): 9 points**

**SCORE: \_\_\_\_ / 80**

**Please submit the sum of responses to ACN.**

*Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.*