Name: ____ **SSN:**__________________ **Date:**_____________

Leisure activities, including exercise routines:____

Occupation, including activities that comprise your workday:_____________________________________

Age: **Height:** **Weight:**
Are you on a work restriction from your doctor? Yes No **Are you latex sensitive? Yes No**
Do you smoke? Yes No **Do you have a pacemaker? Yes No**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: List any medication(s) you are allergic to: ____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. ______________________ 2.__________________________ 3.________________________________

4. ______________________ 5. __________________________ 6.________________________________

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. ______________________ 2.__________________________ 3.________________________________

What date (roughly) did your present symptoms start?____

What do you think caused your symptoms? ____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

Treatment received so far for this problem (chiropractic, injections, etc) ____________________________

Please list special tests performed for this problem (x-ray, MRI, labs, etc) ____________________________

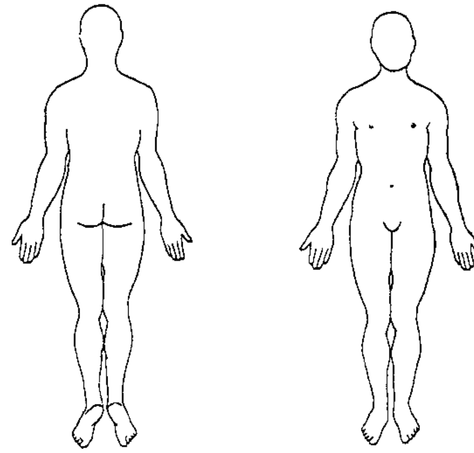
Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**__________ **Treatment rec'd**______________

How long did it take for you to feel better? ____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
1. ____
2. ____
3. ____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
1. ____
2. ____
3. ____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

The worst your pain has been during the past 24 hours: __________

Your current level of pain while completing this survey:__________

The best your pain has been during the past 24 hours: __________

Steppin' Up Physical Therapy

Attendance Policy

We are excited to have the opportunity of helping you improve your physical well-being. Consistency with session attendance as well as consistency with the home program you receive from us will play a key role in your rate of progress. We do understand that you may need to cancel an appointment due to unforeseen circumstances. If you do need to cancel, please call at least 24 hours prior to your appointment. No-shows and same-day cancellations will be assessed a $25 fee which must be paid prior to being seen for the next scheduled appointment.* The limit for the abovementioned occurrences is three after which discharge from our facility will be necessary. These guidelines are enforced to help us stay on schedule and to help ensure that you receive the consistency of care required to efficiently provide you with the results you deserve.

*This Attendance policy is pursuant to any regulations your insurance company may have in place regarding attendance and cancellation/no-show fees.

_______________________________________ ________________

Signature of Patient or Legal Guardian Date

Steppin' Up Physical Therapy, Inc.

5800 Fairfield Ave., Suite 150
Fort Wayne, IN 46805

CONSENT FOR CARE AND TREATMENT

By signing this form, I authorize Steppin' Up Physical Therapy (Provider) to furnish medical care and treatment to ____________________________________ (Patient). This includes any services the Provider feels are necessary in treating Patient and are in cooperation with the referring physician.

____
Initials

FINANCIAL POLICY STATEMENT

We are happy to bill your health insurance company as a courtesy to you. Payment of your estimated share is required at each visit (co-pay, co-insurance, and/or deductible). If your insurance company does not remit payment within sixty (60) days, the balance will be due from you. In the event your insurance company requests a refund of payment or denies coverage for your service, you will be responsible for the balance due. Denials based on "Usual and Customary" will be your responsibility pursuant to any managed care contract in place. If payment is made to you for services provided by Steppin' Up Physical Therapy, you are obligated to promptly pay for those services. **Pre-certification is not a guarantee of payment of benefits. Non-payment (after 60 days of first invoice) will result in the use of a collection agency and/or attorney. Any fees associated with debt collection including collection agency fees, reasonable attorney fees and/or court costs will be extended to Patient (or legal guardian/responsible party).**

____
Initials

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby authorize release to my insurance company of all information necessary for the payment of benefits. I hereby assign payment of benefits by my insurance company to Steppin' Up Physical Therapy, Inc.

____
Initials

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

A Notice of Privacy (NP) is included in this packet of forms. You may read the NP and take it with you. The NP describes how your health information may be used or disclosed and your rights under the Health Insurance Portability and Accountability Act (HIPAA). **Please initial that this form has been offered to you:**

____
Initials

I am giving my consent for release of health or financial information to the following individuals:
(If one of your family members or friends calls in to ask how you are recovering or comes to pick up medical records for you, we cannot give them this information without your consent.)

Name	**Relationship**	**Date of birth**
____________________	____________________	______________
____________________	____________________	______________
____________________	____________________	______________

____
Initials

I understand that I have the right to change (in writing) the above named individuals at any time.

____ ________________________

Patient/Guardian/Responsible Party Date

Steppin' Up Physical Therapy, Inc.
5800 Fairfield Ave., Suite 150
Fort Wayne, IN 46805

Auto Accident/Personal Injury Claims

We are sorry to learn that you have had an injury at the fault of someone else. These types of injuries are considered "third party claims." Third party insurance companies will not pay us for services we provide while caring for you. They may eventually pay you directly once you submit your medical bills if the claim is found in your favor. For this reason, Steppin' Up Physical Therapy will not file third party claims. This gives you three options:

-Billing your personal auto insurance provided you have sufficient "med pay coverage."

-Billing your personal health insurance. Any deductibles, co-pays and/or co-insurances would apply.

-Personal pay. If paying out of pocket, a minimum of $25/visit and a signed Letter of Protection from your attorney is required.

We hope that one of these options will accommodate you well.

"I have read, understand, and agree to the above."

____ _______________

Signature of Patient/Guardian/Responsible Party Date