

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: \_\_\_\_\_

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

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

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

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

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

- |  |                                     |   |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer              | <input type="checkbox"/> diabetes   | <input type="checkbox"/> tuberculosis     |
| <input type="checkbox"/> heart problems      | <input type="checkbox"/> stroke     | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> 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

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**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 \_\_\_\_\_

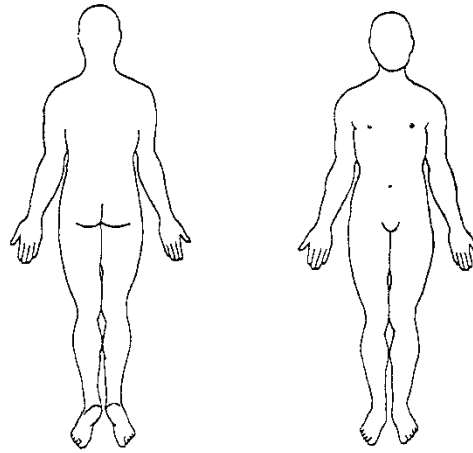
How long did it take for you to feel better? \_\_\_\_\_

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**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
- 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.

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Signature of Patient or Legal Guardian

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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.)

<u>Name</u>	<u>Relationship</u>	<u>Date of birth</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_  
Initials

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

\_\_\_\_\_  
Patient/Guardian/Responsible Party

\_\_\_\_\_  
Date