BACKWAY'S PHYSICAL THERAPY, PLLC: Self-Pay Client INFORMATION FORM

Welcome to our Practice! ***Sorry these forms are lengthy****, but they will assist us in fully evaluating your condition and establishing a meaningful treatment plan for you. Please fill them in to the best of your ability.*

NAME____**AGE**_____**BIRTHDATE**__________**HT**_____**WT**_____**SEX**____
ADDRESS____**CITY**_________________**STATE**_____**ZIP**__________
Phone: Home____________________________ **Work**__________________ Ext_______ **Cell** ___________________________
Email: ____ **PROFESSION**___________________________
MARITAL STATUS: S M W D Sep. **Spouse's Name**____
YOUR SOC. SEC.#_______-______-_________ **SPOUSE'S SOC. SEC.#**_______-______-_________

EMERGENCY CONTACT: Name: _____________________________________**Phone#**_______________________________

RESPONSIBLE PARTY (If not you, who will be responsible for paying the bill?)

Name____ Relationship To You_______________________________________

Address____Zip______________

HomePhone#_______________________________WorkPhone#__________________________Ext________________________

DOCTORS' NAMES & PHONE #	
1ST Dr.	2ND Dr.
Phone #	Phone #

We believe that patients who understand and participate in their health care will achieve the best results.
We respect your individuality, your rights, and your privacy, and we will give you the best care we possibly can.

Please read the following and sign below.

Self-pay client waiver of insurance use:

I am, or my dependent is, entering into care as a "self-pay" client. By signing this agreement, I am stipulating that, even if I currently have health insurance or other insurance benefits that might cover my care, I am choosing not to use those benefits for Physical Therapy or Speech Therapy received at Backway's Physical Therapy, and I am directing the Backway's Physical Therapy staff **not to bill** any insurance on my behalf.

I understand that, if I choose to utilize my insurance benefits at a later date: this cannot be done retroactively; this can only be applied to future dates of service; I must give the treating practitioner at least 48 hours notice, and I must provide the proper medical authorization. Additionally, I understand that changing from a self-pay client to an insurance-based client will necessitate filling in new forms and may necessitate my undergoing a new evaluation procedure to establish medical necessity. **(_____ initials)**

Authorization to leave Messages: In the event that Backway's Physical Therapy cannot speak to me in person regarding the appointments or evaluation results, I give permission to Backway's Physical Therapy to contact me and leave a message on *(check all that apply)*: **(_____ initials)**

Answering Machine ___________ Cell Phone ____________ or other location____________________

Payment: I understand that each visit is to be paid for at the time of the visit, unless prior arrangements have been made. I also understand that no one will be denied medical care if they do not have sufficient funds at the time of the visit. However, payment for such visits is expected in full within 10 (ten) days of the visit, ***whether or not I receive an invoice from you.*** Payments may be made by cash & check, or by credit card **with an added $5 PayPal fee**. If I cannot pay my account in full, I agree to make a payment plan with your office staff **and adhere to it**. If my account becomes overdue, I will be charged late fees (see page 8). **(_____ initials)**

Cancellations: I understand that I will be charged for an appointment which I miss and do not cancel before 8AM of the day **prior** to my scheduled appointment. **(_____ initials)**

I have read the information above, and understand it. I hereby consent to treatment by Backway's Physical Therapy, PLLC.

Signed____**Date**________________________________

BACKWAY'S PHYSICAL THERAPY, PLLC: Initial Appointment Questionnaire: Present Problems

*It is important that you inform us of **ALL** medical/health conditions at your first appointment, and immediately inform us of any changes in your medical/health condition during your course of treatment.*

*Please answer these questions to the best of your ability. **If something is confusing, leave it blank**.*

Information About What Brought You Here:

How did you hear about our services? ______________________________

What are the main symptoms that bring you to Physical Therapy today? ______________________________

____

Onset: When did your symptoms begin (most recent flare-up)? ______________________________

Was the onset sudden, due to an accident/activity, or was the onset gradual? ______________________________

Tests: What diagnostic tests have been performed for your problem (MRI, x-ray, CT) and what are the results?

____

____

Previous Treatment: Have you had any **non-PT** treatment for these symptoms? Yes _____ No _____

If "yes," please describe______________________________

Have you had any previous **Physical Therapy** treatment for these symptoms? Yes _____ No _____

If "yes," please describe______________________________

Other Services: Have you received any **physical therapy, speech therapy, home health or hospice care services in the past year?** Yes _____ No _____ If yes, when? ______________________________

Please explain: ______________________________

Aggravating Factors: What activities make your symptoms worse? ______________________________

____

Easing Factors: What makes your symptoms better? ______________________________

____

Self-care: What are you currently doing for self-care of your symptoms? ______________________________

____

Previous Level of Function: What were you able to do before these symptoms began that you cannot do now?

____

____

What limits do you have to set on your normal activities due to this problem?

Activity	**Any time limits?**	**Any special modifications?**	
Sitting			
Move Sitting to Standing			
Sleeping			
Move Lying to Sitting			
Working			
Computer use			use ☐Laptop? ☐Desktop?
Phone use			use headset Yes☐ No☐
Reading			use Bifocals Yes☐ No☐
Sports or Fitness			
Driving			☐Automatic? ☐Manual?
Recreation (list):			

Goals: What results do you want from Physical Therapy? ______________________________

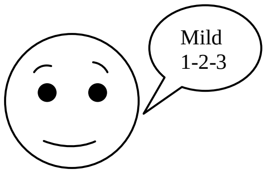
____

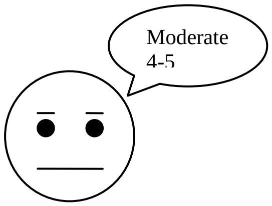
Patient name: ______________________________ Date: ____________

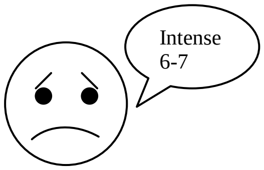
Backway's Physical Therapy Initial Appointment Questionnaire: "0-9" Pain Scale

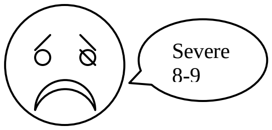
Please use the following information when rating your pain and answering questions regarding your problem.

Draw an "X" on the vertical line to indicate the intensity of your pain.









None

Severe

<u>Mild Pain</u>: Pain does not interfere with most activities. You may use medication or devices such as cushions.

1....Vague Discomfort: Very light, barely noticeable pain.

2....Minor pain: like lightly pinching the webbed tissue at thumb

3....Uncomfortable but Tolerable: Very noticeable pain, like a cut, or an injection, which you can ignore after a while.

<u>Moderate Pain</u>: Pain interferes with many activities & requires lifestyle changes but you remain independent and functional.

4....Annoying: Medium, deep pain, like a toothache or stubbed toe, can't be ignored. You do many activities, but w/pain.

5....Very Uncomfortable: Noticeable pain all the time; you're preoccupied w/managing it; normal lifestyle curtailed.

<u>Intense Pain</u>: Pain interferes with your job or normal interactions. You require some assistance to function.

6....Distressing or Intense: Strong pain dominates your thoughts; thinking is sluggish. Work & social life are curtailed.

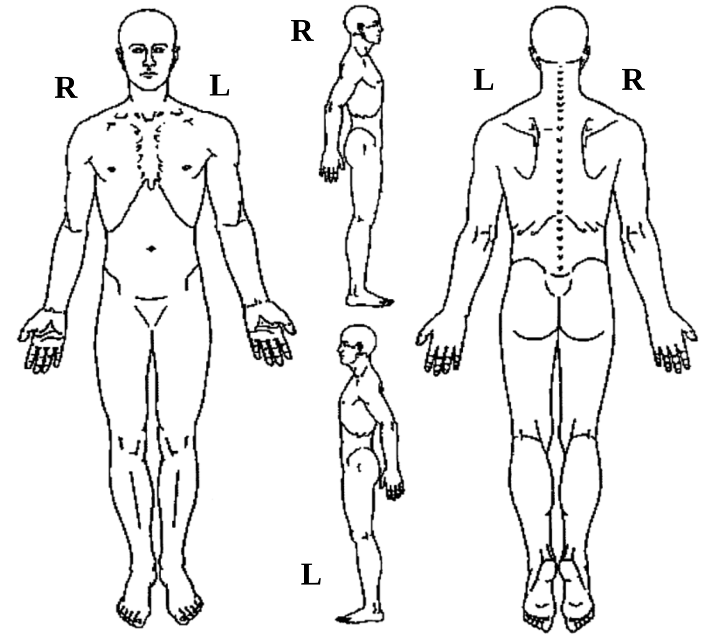
7....Very Intense: Strong pain causes you to think unclearly 50% of the time. You're partly disabled and need help @ home.

<u>Severe</u>: You are unable to engage in normal activities. You find yourself disabled and unable to function independently.

8....Excruciating: Due to the pain, you no longer think clearly; there is no joy in life, and you are willing to take painkillers or have surgery, no matter what the risks.

9....Intolerable or Unbearable: You feel like you're going to pass out. You consider going to the emergency room.

Please indicate, on the figures below, the area(s) in which you are experiencing symptoms:



Also, please list your most painful areas and rate them using the 0-9 scale above *(if you have more than 3 areas, list on the back of this form)*

(1) ____________________________
Usual pain level during a normal day:
Lowest pain level in past week:
Highest pain level in past week:
% of time at highest pain level: ___

(2) ____________________________
Usual pain level during a normal day:
Lowest pain level in past week:
Highest pain level in past week:
% of time at highest pain level: ___

(3) ____________________________
Usual pain level during a normal day:
Lowest pain level in past week:
Highest pain level in past week:
% of time at highest pain level: ___

What % of time are you free of pain? ____%

Patient name: __________________________________ Date: _________ *(PT: Self-Pay Initial Forms Page 3 of 8)*

Backway's PT: Initial Appointment Questionnaire: Modified Oswestry Disability Questionnaire

This questionnaire helps us to understand how much your pain affects your ability to perform everyday activities.
Please check **the one box in each section** that **most** clearly describes your problem ***RIGHT NOW.***

SECTION 1: Overall Pain Intensity

☐ The pain is very mild and comes and goes.
☐ The pain is mild and does not vary much.
☐ The pain is moderate and comes and goes.
☐ The pain is moderate and does not vary much.
☐ The pain is severe and comes and goes.
☐ The pain is severe and does not vary much.

SECTION 2: Personal Care (washing, dressing, etc.)

☐ I do not have to change the way I wash and dress myself in order to avoid pain.
☐ I do not normally change the way I wash or dress myself even though it causes some pain.
☐ Washing and dressing increases my pain, but I can do it without changing my way of doing it.
☐ Washing and dressing increases my pain, and I find it necessary to change the way I do it.
☐ Because of the pain, I am partially unable to wash and dress without help.
☐ Because of the pain, I am completely unable to wash or dress without help.

SECTION 3: Lifting

☐ I can lift heavy weights without increased pain.
☐ I can lift heavy weights but it causes increased pain.
☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they're conveniently positioned (example: on a table, etc.).
☐ Pain prevents me from lifting heavy items. I can manage light-medium weights if they're conveniently positioned.
☐ I can only lift very light weights.
☐ I cannot lift or carry anything at all.

SECTION 4: Walking

☐ I have no pain when walking.
☐ I have some pain when walking but I can still walk my required normal distances.
☐ I cannot walk more than one mile without increasing pain.
☐ I cannot walk more than ½ mile without increasing pain.
☐ I cannot walk more than ¼ mile without increasing pain.
☐ I cannot walk at all without increasing pain.

SECTION 5: Sitting

☐ I can sit in any chair as long as I like without pain.
☐ I can sit only in my favorite chair as long as I like.
☐ Pain prevents me from sitting more than 1 hour.
☐ Pain prevents me from sitting more than ½ hour.
☐ Pain prevents me from sitting for more than 10 minutes.
☐ I avoid sitting because it increases pain immediately.

SECTION 6: Standing

☐ I can stand as long as I want without pain.
☐ I can stand as long as I want but some pain develops.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than ½ hour.
☐ Pain prevents me from standing more than 10 minutes.
☐ I avoid standing because it increases my pain immediately.

SECTION 7: Sleeping

☐ I have no pain while in bed.
☐ I get pain in bed but it does not prevent me from sleeping well.
☐ Because of pain, I sleep only ¾ of my normal time.
☐ Because of pain, I sleep only ½ of my normal time.
☐ Because of pain, I sleep only ¼ of my normal time
☐ Pain prevents me from sleeping at all.

SECTION 8: Social Life / Recreation

☐ My social/recreation activities are normal and without pain.
☐ My social/recreation activities are normal, but increase the degree of pain.
☐ Pain has little effect on my social/recreation activities except limiting more energetic interests, e.g. dancing, etc.
☐ Pain restricts my social/recreation activities and I do not go out very often.
☐ Pain restricts my social/recreation activities to my home.
☐ I have hardly any social/recreation life because of pain.

SECTION 9: Traveling / Driving

☐ I can travel/drive without increased pain.
☐ I can travel/drive unrestricted, but it increases my pain.
☐ My pain restricts travel/drives of over 2 hours.
☐ My pain restricts my travel/drives of over 1 hour.
☐ My pain restricts my travel/driving to short necessary journeys under ½ hour.
☐ Pain prevents all forms of travel except that done lying down, or for visits to the doctor, therapist or hospital.

SECTION 10: Employment / Homemaking

☐ My normal job/homemaking duties do not cause pain.
☐ My normal job/homemaking duties increase my pain, but I can still perform all that is required of me.
☐ I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities like lifting, vacuuming, etc.
☐ Pain prevents me from doing anything but light duties.
☐ Pain prevents me from doing even light duties.
☐ Pain prevents me from performing any job or homemaking chores.

(for therapist's use only) **DI Score______%**

Patient name: ___________________________________ Date: __________

Backway's PT Initial Appointment Questionnaire: *Health History Questionnaire*

Please give names of *all* other Health Care Professionals you are seeing (Massage, Psychologist, Chiropractor, Acupuncture, etc.):

____

____

"Substance" Use	**Never**	**Rarely**	**Daily**	**Current use: how much?**	**Past use:**
Alcohol	☐	☐	☐	_____________ drinks/day	not in _______ wks/months/yrs
Tobacco	☐	☐	☐	_____________ packs/day	not in _______ wks/months/yrs
Recreational Drugs	☐	☐	☐	Explain:	not in _______ wks/months/yrs

Please indicate if you now have, or in the past had, any of the following (check all that apply):

Nervous System

- ☐ Head / Brain Injury
- ☐ Stroke
- ☐ TIA's
- ☐ MS
- ☐ Parkinson's
- ☐ Peripheral Neuropathy
- ☐ Epilepsy / Seizure Disorder
- ☐ other Neurologic problems *(list)*

Respiratory System

- ☐ Asthma
- ☐ Emphysema or COPD
- ☐ Pneumonia
- ☐ Sinus surgeries
- ☐ Deviated Septum
- ☐ Allergies
- ☐ other Lung problems *(list)*

Digestive & Eliminatory

- ☐ IBS
- ☐ Frequent Loose Stools
- ☐ Frequent Constipation
- ☐ Discomfort following meals
- ☐ Hiatal Hernia
- ☐ Disordered Eating
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Urinary Incontinence

Endocrine & Immune System

- ☐ AIDS
- ☐ HIV positive
- ☐ Hepatitis A B C (circle)
- ☐ Diabetes Type 1 or 2 (circle)
- ☐ Thyroid Imbalance
- ☐ Low Blood Sugar
- ☐ Cancer

Please describe:

____

Cardiac / Circulation System

- ☐ Heart Attack
- ☐ Angina or Chest Pain
- ☐ Irregular Heart Rhythm
- ☐ Stents placed
- ☐ Bypass Surgery
- ☐ Heart Failure
- ☐ Pacemaker or Defibrillator
- ☐ Aneurism
- ☐ Blood Clot
- ☐ Bleeding / Bruising tendency
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Neck, arm, jaw or upper back pain with exertion
- ☐ High Blood Pressure
- ☐ High Cholesterol

Musculoskeletal & Connective Tissue Conditions

- ☐ Osteoarthritis
- ☐ Spinal Stenosis
- ☐ Spondylolisthesis
- ☐ Herniated Disc Neck
- ☐ Herniated Disc Low Back
- ☐ Osteoporosis or Osteopenia
- ☐ Compression Fractures
- ☐ Stress Fracture
- ☐ Carpal Tunnel Syndrome
- ☐ Thoracic Outlet Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Migraine
- ☐ Frequent Headaches
- ☐ TMJ
- ☐ Teeth Grinding
- ☐ Other: *(list)*

Traumas (please note year)

- ☐ Whiplash
- ☐ Fractures / broken bones *(list)*
- ☐ Dislocations ______________
- ☐ Ligament Tear ____________
- ☐ Meniscus Tear_____________
- ☐ Bad Sprains *(list)*
- ☐ Motor Vehicle Accident(s)
  - 1) When?______________
    - Driver ☐ Passenger ☐
    - Injured: Yes ☐ No ☐
    - If yes, what ____________
  - 2) When?______________
    - Driver ☐ Passenger ☐
    - Injured: Yes ☐ No ☐
    - If yes, what ____________
  - 3) When?______________
    - Driver ☐ Passenger ☐
    - Injured: Yes ☐ No ☐
    - If yes, what ____________
- ☐ Other: *(list)*

Patient name: ____________________________________ Date: ____________

Backway’s PT: Health History Questionnaire (continued)

General Challenges

☐ Falls. If yes, are they frequent (more than 2 in a year)? ☐
☐ Shortness of Breath
  ☐ on exertion ☐ lying flat
☐ Dizziness
☐ Balance Disturbance
☐ Anemia
☐ Memory Loss
☐ Hearing Loss
☐ Vision Loss
☐ Sleep Apnea
☐ Insomnia
☐ Unusual Fatigue
☐ Alcoholism
☐ Substance Abuse (current or in recovery)
☐ Clinical Depression
☐ Mental or Emotional disorders or difficulties

Please Explain:

Surgeries *Please list **all** surgical procedures with approximate dates **or** your age at the time* (include metal & plastic implants, joint replacements, cosmetic & reconstructive surgeries, etc.)

Other Illnesses, Accidents & Hospitalizations
List, if not included elsewhere:

Please list any other information regarding your medical or health history that you believe we should know:

Please look over this Initial Questionnaire form carefully & be sure it is complete.

Providing incorrect information can be dangerous to your health.

Please Note*: Your Therapist has the right to dismiss from treatment any patient who intentionally withholds pertinent medical / health information.*

Thank you *for providing this information for us. Please remember to immediately inform us of any changes in your medical/health condition during your course of treatment.*

The following forms *will tell us about your medications & with whom we may share your information. They ask you for your signatures to give us permissions for treatment, and communication purposes; and to indicate you understand our office policies and how the Privacy Act (HIPAA) works.*

Patient name: ___________________________________ Date: _________

Backway's Physical Therapy: Intake Form Patient Medication List & Recent Fall History

Have you fallen in the past 12 months? ☐Yes ☐No **How many times?** _______ **Were you injured from falling?** ☐Yes ☐ No

Please look at the labels on your medications & supplements; then list them below. This includes all prescription, over-the-counter, herbals, vitamins, minerals and dietary/nutritional supplements you take routinely, and/or on an as-needed basis.

Medication or Supplement Name	**Dosage**	**How many times/day?**	**Is this taken by mouth or other route?**	**What condition is this for?**	**"May cause dizziness" label on it?**	**Does this med make you dizzy?**
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No

Therapist notes: Is form complete? ☐ Yes, ☐ No. If no, reason not completed: ☐ Pt refused ☐ Emergency ☐ Pt cog unable **(initials:** ________)

Patient Name: ____ **Date:** ______________________

Backway's Physical Therapy, PLLC **SELF PAY – Authorizations & Office/Financial Policy Form**

You have the right to revoke the following authorizations, unless we have already taken action relying on the authorization. Requests to revoke any authorizations must be made in writing. ___________ (please initial)

****

***Optional*: Consent for Use of Information for Presentations, Research and/or Publications (optional)**
I grant permission, now and in future, to Backway's Physical Therapy, or their duly appointed representative, to use my records, or those of my dependent, for other consultations and for professional education, research and publications, **providing reasonable precautions are taken to guard against the disclosure of the client's identity**. My signing of this authorization is **not** a condition to receive treatment by Backway's Physical Therapy personnel.

(Optional) Patient's/Guardian's Signature _____________________________Date ___________

****

All Authorizations below are Mandatory:

Receipt of HIPAA Patient Privacy Notice: My signature below indicates that I have received the HIPAA Patient Privacy Notice. I consent to your use and disclosure of protected health information about me for treatment, payment, health care operations, and/or as required by law and by HIPAA. **(_____ initials)**

Consent for Treatment: I hereby authorize the professional staff of Backway's Physical Therapy to evaluate and treat me or my dependent. During the course of evaluation and treatment, I authorize the licensed personnel at Backway's Physical Therapy to use any and all techniques they have been trained to use, which they believe will benefit me, in order to help me recover. I have the right to refuse a specific technique or form of treatment, if I so choose. **(_____ initials)**

Consent for Mutual Exchange of Information: I authorize the mutual exchange of information regarding myself, or my dependent, between the Backway's Physical Therapy staff members, and all professional practitioners involved in my healthcare, or that of my dependent, at any time (i.e. doctor, chiropractor, counselor, etc). Your office may also talk with the non-practitioner persons listed below about my health information: **(_____ initials)**

☐ Spouse	Name:	phone#:
☐ Child	Name:	phone#:
☐ Parent	Name:	phone#:
☐ Other	Name:	phone#:
☐ Other	Name:	phone#:

Missed appointments: No-Shows; Frequent Cancelations & Cancelations Without Adequate Notice:
If I need to cancel an appointment, I must let you know before 8AM of the day prior to my scheduled appointment to avoid a cancelation fee. *If I cancel late*, or if I do not attend my appointment, **I will be charged** a missed-appointment fee which may be equal to the full treatment session price. **(_____ initials)**

Overdue Accounts: All overdue accounts are subject to late fees (table below). Self-pay accounts start accruing fees 30 days after service is rendered. Liens start accruing fees 90 days after discharge from therapy.

Past Due Balance	$20 - $100	$101 to $750	$751 to $3000	Greater than $3000
Monthly Late Fee	$15	$25	$50	$75

Returned check fee: A fee of $25 is charged on all returned checks.

Collections: Returned checks and failure to pay account balances overdue for 90 days may result in our referring your account to an outside collection service. **(_____ initials)**

We may refuse service to a client under certain circumstances. Refusal is usually due to, but is not limited to: non-payment of past accounts; repeated missed/canceled appointments; inappropriate behavior; and the therapists' opinion that our services won't benefit a client or aren't medically necessary. **(_____ initials)**

I have read and fully understand the above statements and agree that they apply to all treatments that I receive at Backway's Physical Therapy. I agree to pay for all services rendered at the time of service, unless previous arrangements have been made.

➔Patient's/Guardian's Signature ____________________________________ Date ___________

Patient's Printed Name: ____