

Summit Physical Therapy

100 Wilhaven Drive, Ste. 100, McMurray, PA 15317 Phone: 724-941-3727 Fax: 724-941-3761

First Name: _____ MI: _____ Last Name: _____

Nick Name: _____ SSN: _____ - _____ - _____ Gender: M/F D.O.B.: _____ - _____ - _____

Marital Status: (S / M / D / W) Patient Status: (NA / Employed / Retired / Full-time or Part-time Student)

Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Home #: (_____) _____ Cell #: (_____) _____ Work #: (_____) _____

Appointment Reminder: Email Text Preferred method of communication? Phone / Email / Text / Mail

Approximate Date of Injury/Reason for Physical Therapy: _____

Emergency Contact /Relationship: _____ Phone #: (_____) _____

This contact is permitted to discuss the medical conditions of the patient.

Family Physician: _____ Phone #: (_____) _____

Referring Physician: _____ Phone #: (_____) _____

Employer Name: _____ Phone #: (_____) _____

Name of Insurance: _____

Subscriber's Name/D.O.B.: _____

Subscriber's Employer: _____

Are you receiving home care at the present time? Yes No

If yes, which home care company is providing the services? _____

If no, when were you discharged? _____

I hereby authorize **SUMMIT PHYSICAL THERAPY** to release any information concerning my case to the appropriate individuals or insurance companies. I hereby accept full responsibility for any amount not covered by my insurance. I authorize payment of medical benefits to **SUMMIT PHYSICAL THERAPY**. I understand an interest of 1.5% will be applied monthly to all overdue accounts and all monthly payments are a minimum of 25% of the balance.

TREATMENT CONSENT AUTHORIZATION: I am fully aware of my medical diagnosis and prognosis and consent to allow **SUMMIT PHYSICAL THERAPY** to provide treatment for my condition.

SIGNATURE: _____ PRINT NAME: _____

DATE: _____ Yes, Summit Physical Therapy may leave messages on my phone.

Summit Physical Therapy - Outpatient Medical History

Name: _____ **Height:** _____ **Weight:** _____ **Today's Date:** _____

Existing or relevant previous conditions:

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	MRSA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema/Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gallbladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Impairments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High/Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strokes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulation Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metal Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Describe any other conditions or precautions: _____

Fall History

Is your injury the result of a fall in the past year? Yes No Two or more falls in the past year? Yes No

Surgical History *(Please indicate at least the year surgery was performed and Left or Right sided injuries)*

Body Region: _____ Surgery Type: _____ Date: _____

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Current Medications: *(Dosage must be included)*

Drug: _____ Dosage: _____ Frequency: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Reason Taking: _____

Currently not taking any medications

Are you allergic to any medications? Yes No If yes, please list _____

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Place an X in the box if any of these diagnostic tests have ever been performed for your current injury/condition.

	<i>Test</i>	<i>Date</i>	<i>Results</i>
	X-Rays		
	MRI		
	CAT scan		
	EMG/NCV		
	Bone scan		

Description of problem: _____

Was it due to an injury? Yes No If yes, what was the date and how did it happen? _____

Was it a gradual onset? Yes No If yes, when did it begin? _____

Is the problem work-related? Yes No If yes, please explain how it is related? _____

Were you involved in a motor vehicle accident? Yes No If yes, please describe. _____

Is litigation (law suit) involved? Yes No If yes, who is your attorney? _____

Have you ever had any previous injuries involving the same area? Yes No If yes, please describe the injury and approximate date(s). _____

Do you smoke? Yes No If yes, how much? _____ Are you pregnant? Yes No

I, the undersigned, state I have answered the questionnaire to the best of my knowledge.

Signature _____ Date _____

We want to know!

How did you hear about Summit?

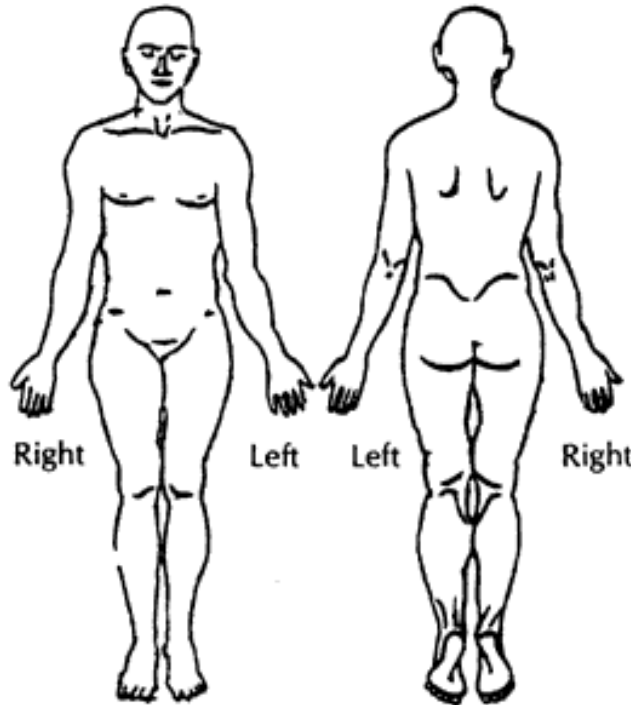
Physician Insurance Family Member Friend Social Media

Summit Physical Therapy - Pain Diagram Form

Use the diagram below to indicate where you feel symptoms **right now**. Use the **key** to indicate how the symptoms feel.

KEY

Pins and Needles = OOOOOO Stabbing = ////////////// Burning = XXXXXXXX Deep Ache = ZZZZZZZZ



1. What is your pain level right NOW on a scale from 0 (no pain) to 10 (extreme pain)? _____
2. What has been your WORST pain level in the last 24 hours on a scale from 0 to 10? _____
3. What has been your BEST pain level in the last 24 hours on a scale from 0 to 10? _____

Place an X in the box(es) that best describe your pain.

<input type="checkbox"/> Constant	<input type="checkbox"/> Increasing	<input type="checkbox"/> Night Pain	<input type="checkbox"/> Dull/achy pain
<input type="checkbox"/> Intermittent	<input type="checkbox"/> Decreasing	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Pain upon walking
<input type="checkbox"/> Occasional	<input type="checkbox"/> Static	<input type="checkbox"/> Sharp pain	<input type="checkbox"/> After standing or walking too long
Pain is aggravated by:			
Pain is eased by:			

1. Have you been treated by a physical therapist? Yes No
2. Have you been treated by a chiropractor? Yes No
3. What were you treated for? _____

Summit Physical Therapy

Acknowledgement of Receipt of Notice of Privacy Practices

Last Name: _____ **First Name:** _____ **MI:** _____ **DOB:** _____

In general, any information you receive about your health care, or payment for the care, is considered confidential and protected by our practice. We may need to use your protected health information to carry out treatment, payment health care operations and/or other purposes. Our notice of privacy practices provides a more complete description of permitted uses and disclosures.

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Please print patient's full name

Date

Signature of patient or patient representative

Relation

Consent and Release

1. I am consenting to examination and treatment by physicians and allied health professionals employed by Summit Physical Therapy. I understand I will not be involved in research or experimental procedures without my knowledge or consent.
2. I am responsible for paying for all services provided to me, which may include collection fees, and agree any insurance benefits for my account will be paid directly to Summit Physical Therapy. I authorize Summit Physical Therapy to submit insurance claims on my behalf. I certify all information given by me in applying for payment by any third party is true and accurate.
3. I authorize release of my medical bills to the person whose medical insurance is paying all or part of my account.
4. I understand I may receive separate bills for professional interpretation and/or for hospital outpatient services.
5. I authorize Summit Physical Therapy to submit Medicare claims on my behalf and request payment of authorized Medicare benefits be made directly to Summit Physical Therapy for any services provided. Additionally, I authorize release of any medical information regarding my care in order to determine potential payable services.

I authorize Summit Physical Therapy to disclose my personal health information to the following individual(s) who are involved in my care:

Printed Name of Individual

Relationship to Patient

Telephone Number

Printed Name of Individual

Relationship to Patient

Telephone Number

I have been given the opportunity to ask questions about this document. By signing below, I declare that I understand the above information:

Signature of Patient or Representative

Date