## PATIENT INFORMATION

**Referring Physician:**_____

**Last Name:**_____ **First Name:**_____ **M.I.**_____ **Date of Birth:**_____

SSN:_____(optional) Sex: **F** or **M** Age:_____ Marital Status: M___ S___ D___ W___

Home Address:_____City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Emergency contact name:_____ Phone:_____ Relation:_____

Family Physician:_____ Phone:_____

Where did you hear about us? _____

**Reason for visit or type of injury: (circle)** Job Related Auto Accident Liability Situation Sports Other

Date of Onset/Injury:_____ Body Part(s) Being Treated:_____
Explanation:_____

*Are you taking any medications? If so, please list below (or provide a copy):* *COPY PROVIDED* *Yes* *No*

| MEDICATIONS, herbs, vitamins, supplements | DOSAGE | FREQUENCY | METHOD (orally, etc) |
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**EMPLOYMENT INFORMATION:**
**Employer:**_____ **Occupation:**_____ **Phone:**_____
**Address:**_____ **City:**_____ **State:**_____ **Zip:**_____
*Circle Status: FT PT Unemployed Disabled Retired Student*

**INSURANCE INFORMATION:**
**PRIMARY Insurance Company:**_____ **Relation to Insured:**_____
Name of Insured:_____ Insured's Employer:_____DOB:_____

**SECONDARY Insurance Company:**_____**Relation to Insured:**_____
Name of Insured:_____ Insured's Employer:_____ DOB:_____
***If Medicare is secondary state reason:*** working aged benefit_____; disabled benefit_____; veteran's admin_____;
work comp____; public health_____; other_____

***I authorize the release of any medical information to process insurance claims and further authorize payment of medical benefits to HEALTHY EXPECTATIONS, INC.***

**Authorized Signature:**_____ **Date:**_____

# PATIENT HISTORY QUESTIONNAIRE

**NAME:**_____ **DATE:**_____

**1.** What is your primary problem?_____

**2.** How did your problem begin? _____

**3.** What date did your problem begin? _____

**4.** Have you had anything similar before? **YES** or **NO** If yes, describe: _____
_____

**5.** Were you free of symptoms before this onset? **YES** or **NO**_____

**6.** What, if any, treatment have you had for this current condition? _____

**7.** Please rate your pain or dizziness/unsteadiness level on a scale of 0-10, (10 = emergency room, 0 = no pain):
**RIGHT NOW:**_____ **BEST:**_____ **WORST:**_____

**8.** On a functional scale of 0-100% (100% is normal), where do you feel you are functioning? _____

**9.** Is your pain or dizziness/unsteadiness:
**____CONSTANT-***no change with activity* **____INTERMITTENT** **___CONTINUOUS-***changes with activity*

**10.** Do you experience pain, tingling, or numbness traveling beyond the area or dysfunction? **YES** or **NO**
**If yes,** where? _____

**11.** When is your pain or dizziness/unsteadiness level the least?_____

**12.** What makes the pain or dizziness/unsteadiness worse? _____

**PERSONAL MEDICAL HISTORY -** Do you have any of the following problems?

| | | |
|---|---|---|
| ___ Lumps, Growths, or Tumors | ___ Skin or Dermatologic Condition | ___ Recurrent Infections Condition |
| ___ High Blood Pressure | ___ Birth Defect or Abnormalities | ___ Circulatory/ Vascular Condition |
| ___ Low Blood Pressure | ___ Blood Condition | ___ Neurological Condition |
| ___ Gallbladder Condition | ___ Liver Condition | ___ Cancer |
| ___ Respiratory/ Lung Condition | ___ Sinus Condition | ___ Heart Ailment |
| ___ Epilepsy or Convulsive Condition | ___ Rheumatic Fever | ___ Hernia or Rupture |
| ___ Diabetes or Hypoglycemia | ___ Rheumatism, Arthritis | ___ Osteoporosis |
| ___ Ear, Nose Throat, Eye Problems | ___ Kidney/ Bladder Condition | ___ Stomach or Intestine Condition |

**JOB STATUS:**

**1.** Are you currently working? **YES** or **NO** Restrictions: _____

**2.** If not working, what was the last date of work?_____

**3.** What are your goals or expectations from receiving physical therapy? _____

**FALLS: (*Definition of "Fall"* -** *sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.)*

Have you have 2 or more falls in the past 12 months? **YES** **NO**

Have you had one fall with injury in the past 12 months? **YES** **NO**

## COMMITMENT TO THERAPY

We are committed to your recovery. We have reserved a 45-60 minute one-on-one appointment with your therapist, dedicated to helping you reach your goals. We are requesting the same level of commitment from you. We take this subject seriously because it can make the difference between whether you succeed in your treatment or not. To ensure optimal results, and to respect the commitment in time and resources that we have made to you, it is very important for you to attend therapy consistently. We expect you to keep your scheduled appointments. If you need to reschedule an appointment, we ask that you give us at least a 24 hour notice. If a **cancellation without a 24 hour notice or a no-show to a scheduled appointment occurs, you will be charged a $25.00 fee.**

Patient signature:_____ Date: _____

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

If you have anyone such as a spouse, family member, friend, etc. that you would like to be able to schedule appointments, discuss medical information, account information, etc. please list their information below for authorization and release.

Name: _____ Phone: _____ Relationship_____

Name: _____ Phone: _____ Relationship_____

Name: _____ Phone: _____ Relationship_____

***I have received the Notice of Privacy Practices (HIPPA) from Healthy Expectations. A copy of the HIPPA policy will be given to you when you check in for your first visit.***

Patient signature:_____ Date: _____

## ASSIGNMENT OF MEDICAL BENEFITS AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

### *ASSIGNMENT OF BENEFITS*

The undersigned hereby assign(s) to HEALTHY EXPECTATIONS, INC. ("Provider"), and all private medical insurance benefits (primary and secondary) or Medicare benefits to which the patient may be entitled for services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file for all such benefits on the patient's behalf.

### *FINANCIAL RESPONSIBILITY*

1. If Provider is billing your insurance, the undersigned fully understands that he/she may be financially responsible for services rendered and for any balance after insurance has processed all claims.
2. The undersigned agrees to complete other documents that may be requested by your insurance or Provider to complete the process of your treatment or claims.
3. If this claim is determined by the undersigned's workers compensation carrier to be a non-work related, the undersigned agrees to be financially responsible.
4. I further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made at discharge, or within 30 days of discharge, to pay for in-office processing fees. I further agree to pay collection costs and reasonable attorney fees if this account is placed in the hands of a collection agency or attorney.
5. The undersigned agrees to call and notify Provider if unable to keep his/her scheduled appointment. Provider has the right to bill the patient a $25.00 fee if the patient is a **NO SHOW** or **NO CALL.** If 2 or more appointments are **NO SHOW** or **NO CALL** service(s) may be discontinued due to non-compliance.

## AUTHORIZATION FOR TREATMENT AND INFORMATION RELEASE

### *AUTHORIZATION FOR TREATMENT*

1. The undersigned hereby authorizes Provider to render any and all therapy services, or other related services that Provider feels are necessary or advisable to the patient in conjunction with physician referral. The patient shall cooperate fully with all requests to Provider in connection with Provider's rendition of therapy and related services.
2. The undersigned hereby certifies that all information given by the undersigned in applying for payment under Title XVII of the Social Security Act, provided to Provider is true and correct in all respects.

### *RELEASE OF INFORMATION*

The undersigned hereby authorizes Provider to disclose any information furnished by Provider or obtained by Provider in connection with the patient's treatment to your referring physician(s) or your insurance company.

***I have read the above and fully understand the terms of this document.***

_____

Patient's Printed Name

_____ _____

Patient's Signature Date Witness Date