

CUTTING EDGE PHYSICAL THERAPY PATIENT DATA SHEET

DO NOT EMAIL The electronic form is provided for your convenience. With respect to responding to this form, please do not send via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

First: _____ **MI:** _____ **Last:** _____

Date of Birth: _____ **Age:** _____ **Gender:** Male Female

Physical Address: _____

Mailing Address: _____

Phone Numbers:	OK To Call	Best Time To Call
Home: _____	<input type="checkbox"/>	_____
Work: _____	<input type="checkbox"/>	_____
Cell: _____	<input type="checkbox"/>	_____

May we send you text messages for your appointment reminders to the number(s) listed above? By marking "Yes" below, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.
 Yes No

May we send you emails relating to your care with us? Yes No
By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.
Email: _____

Preferred language: _____ **Interpreter required?** Yes

Date of Injury: _____ **Referring Physician:** _____
Injury Area: _____ **Auto or Work Accident:** Auto Work N/A
Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? Yes No
Are you currently receiving or have you received other therapy services in the last 60 days? Yes No

Marital Status:
 Married Single Divorced Widowed Separated Unknown

Student Status:
 Full-Time Part-Time None

EMPLOYMENT STATUS

Employment Status:

Active Military Full-Time None Part-Time Retired Self Employed

Employer: _____ **Occupation:** _____

Address: _____

Phone: _____

Employer: _____ **Occupation:** _____

Address: _____

Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

How did you hear about us?

- | | | |
|---|---|---|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Hospital | <input type="checkbox"/> Marketing Ad - Print |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Cross Referral | <input type="checkbox"/> Marketing Ad - TV |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor | <input type="checkbox"/> Self | <input type="checkbox"/> Marketing Ad - Facebook |
| <input type="checkbox"/> School | <input type="checkbox"/> Screens - Open Houses | <input type="checkbox"/> Marketing Ad - Other _____ |

Specify if other : _____

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

Name Relationship

Name Relationship

Signature of Patient

Date

PATIENT INTAKE AND CONSENT FORM

Internal Use Only:	A/C#	Name	A/C Type	Office #
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CONSENT TO TREATMENT

I consent to rehabilitation and related services at:

CUTTING EDGE PHYSICAL THERAPY

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. Initials: _____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. Initials: _____

LIABILITY

I know and agree that: CUTTING EDGE PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. Initials: _____

WAIVER AND RELEASE

I hereby release, discharge and acquit: CUTTING EDGE PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. Initials: _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: CUTTING EDGE PHYSICAL THERAPY. I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. Initials: _____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. Initials: _____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. Initials: _____

I acknowledge receipt of the Statement of Patient Rights. Initials: _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Witness Signature _____

CUTTING EDGE PHYSICAL THERAPY MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____
 REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____
 PRIMARY CARE PHYSICIAN'S NAME: _____ ARE YOU PRESENTLY WORKING? YES NO
 CAUSE OF INJURY OR ONSET: _____ DATE OF NEXT MD APPT: _____

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
 IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: _____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?
 1. _____
 2. _____
 3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?
 1. _____
 2. _____
 3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR
 DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? _____ WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN _____
 AND WHY _____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
 WHAT WAS DONE? / WHAT WERE THE RESULTS?:

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
 WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
 FOR HOW LONG? _____

CURRENT MEDICATIONS: _____

ALLERGIES: Medication _____ Reaction _____ Other _____ Reaction _____
 ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction _____
 Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction _____

- DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)
- | | | |
|--|---|---|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> ASTHMA <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> COPD <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> CARDIOVASCULAR PROBLEMS | <input type="checkbox"/> FRACTURES | <input type="checkbox"/> Other |
| <input type="checkbox"/> HOLTER MONITOR - currently wearing? | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SEIZURES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> HEPATITIS/HIV | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> BLOOD THINNERS (Anticoagulants) |
| <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> MRSA (Methicillin Resistant Staphylococcus Aureus) | |
| <input type="checkbox"/> CURRENTLY PREGNANT | <input type="checkbox"/> OSTEOPOROSIS | |

If checked any above, explain: _____

ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____ Date _____

Patient Name: _____ Account #: _____ Date: _____

List Medications (M130)

Name of Medication	Dosage	Amount	How Often
1			
2			
3			
4			
5			
6			

Over the Counter Medications (check all you take regularly)

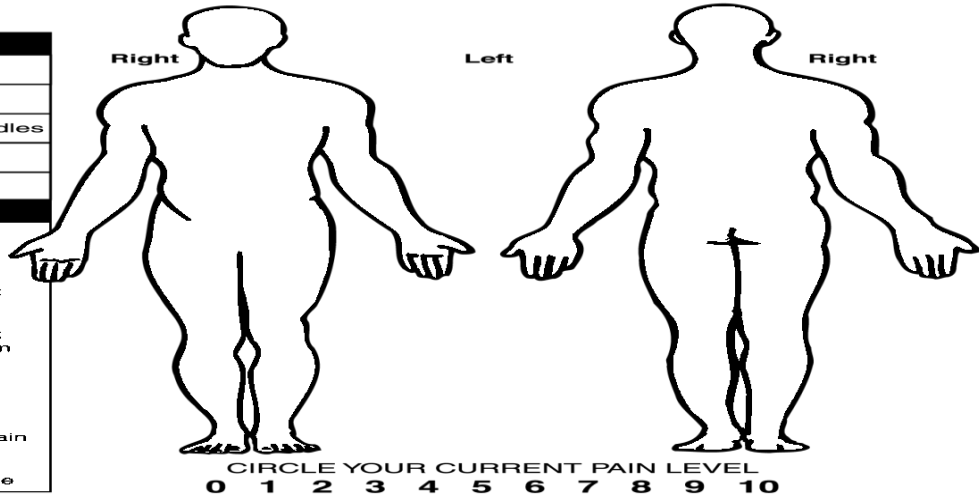
- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Aspirin/Ibuprofen | <input type="checkbox"/> Cold Medicine | <input type="checkbox"/> Laxative | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Cough Medicine | <input type="checkbox"/> Diet Pills | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sleeping aids | <input type="checkbox"/> Allergy Relief | <input type="checkbox"/> Vitamin/Herbal supplements | |

Complete the Pain Assessment Drawing (M131)

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below. **Note:** Documentation of a follow-up plan is required when pain is present.

- RIGHT HANDED
 LEFT HANDED

KEY	
//////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching
PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; it may make you contemplate suicide



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Calculate BMI and ✓ Appropriate Box (M128)

BMI = $\frac{\text{Weight (lb)}}{[\text{Height (in)} \times \text{Height (in)}]} \times 703$

Weight (lbs): _____

Height (inches): _____

BMI = _____

Age 65 years and older: (·)

- Within Normal Parameters [BMI = ≥ 23 and < 30]
- Above Normal Parameters [BMI ≥ 30]
- Below Normal Parameters [BMI < 23]

Age 18 – 64 years: (·)

- Within Normal Parameters [BMI = ≥ 18.5 and < 25]
- Above Normal Parameters [BMI ≥ 25]
- Below Normal Parameters [BMI < 18.5]

Note: Documentation of a follow-up plan is required when BMI is outside of normal parameters.

Therapist Signature

Therapist Name (Printed), Credentials

Date

**CONSENT TO USE OF LIKENESS AND
TESTIMONIAL AND RELEASE**

I, _____, hereby consent to allow CUTTING EDGE PHYSICAL THERAPY and its employees, agents, partners, and affiliates (collectively "Clinic"), to use my name, photograph, videotape/audiotape recording, and/or written testimonial ("marketing materials") in Clinic's marketing brochures, publications, and/or on their website and social media accounts, including but not limited to Facebook and Twitter, to promote the services offered by Clinic. I understand and agree that these marketing materials are owned by Clinic and will not be returned to me.

I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization.

Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

Participant Name

Date

Parent/Legal Guardian (If Participant is a Minor)

HIPAA AUTHORIZATION FOR DISCLOSURE OF PHI

I, _____, hereby consent and authorize CUTTING EDGE PHYSICAL THERAPY and its employees, agents, partners, and affiliates (collectively "Clinic") to disclose my Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for marketing purposes, as stated below. I understand that subsequent disclosures by recipients of my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

Further, I authorize Clinic to disclose my PHI, in the form of written statements, photographs, and videotape/audiotape recordings, for purposes of promoting and advertising Clinic's services.

I understand that I may revoke this authorization at any time by giving written notice to Clinic, except to the extent that Clinic and its agents, employees, and representatives may have taken action in reliance on this authorization.

This authorization is effective on the date stated below for an indefinite period of time. A photocopy of this authorization form is valid and should be given the same force and effect as the original.

Participant Name

Date

Parent/Legal Guardian (If Participant is a Minor)