

Current Problem

Date _____

Name (First, MI, Last) _____

Date of Birth _____

Age _____

Male

Female

Primary Care
Physician

Referring Physician

Height (feet/inches) _____

Weight (lbs.) _____

Right Handed

Left Handed

Both

Current Problem:

Right

Left

Both

Numbness:

Right

Left

Both

Shoulder

Hand

Mid Back

Foot

Lower Leg

Upper Arm

Finger

Lower Back

Ankle

Upper Back

Elbow

Thumb

Hip

Knee

Forearm

Neck

Thigh

Wrist

Other (describe) _____

Date of Injury/Onset of problem (if known): _____

Describe how and where injury occurred: _____

Describe Severity of Pain:

Mild

Moderate

Severe

Night Pain

Does the Pain Radiate:

Yes

No

If Yes, radiates to
(describe) _____

Quality of Pain:

Aching

Burning

Dull

Piercing

Sharp

Throbbing

Other

Since Problem Started is
it:

Getting Better

Getting Worse

Improving

No Change

What makes symptoms
better:

Rest

Heat

Elevation

Ice

Other _____

What make symptoms worse:

Bending

Lifting

Squatting

Standing

Twisting

Stairs

Walking

Pushing

Exercise

Lying in Bed

Coughing

Sneezing

Other

Prior Treatment for this
Problem:

Medication

Physical Therapy

Steroid Inj.

Cast

Surgery

Other

Prior Diagnostic Tests: {Have you ever had any of the following, if so, when and where?}

X-ray

CT Scan

MRI

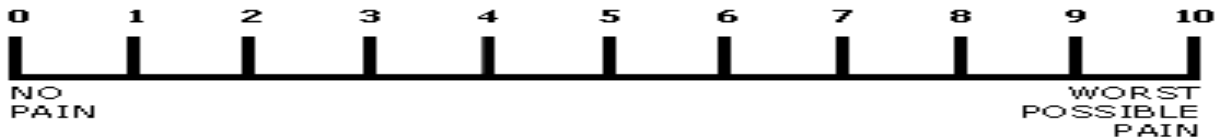
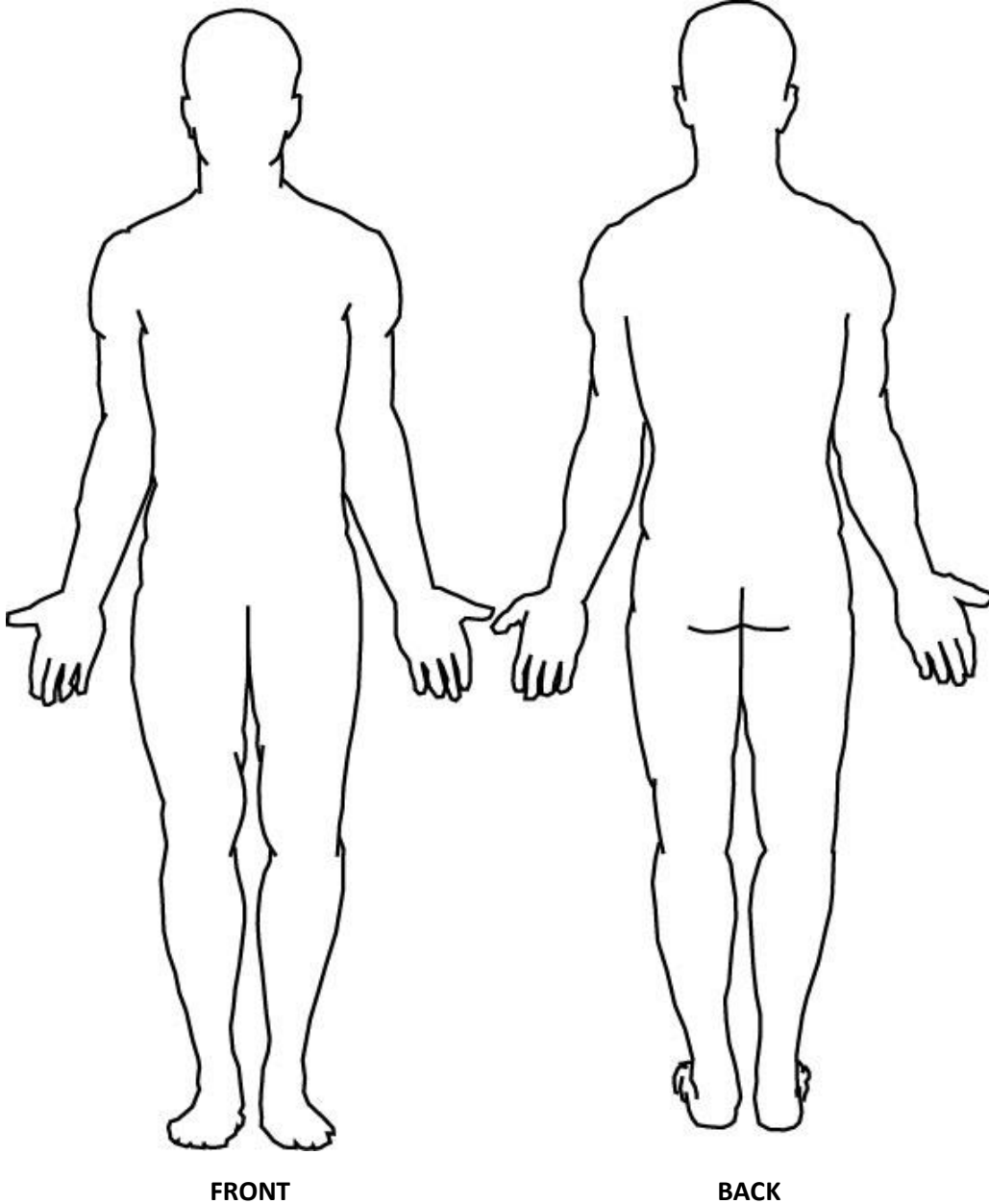
Other

Pre-existing condition

Pain Drawing Grid Assessment

Using the abbreviations below, please draw the location of your pain on the body outline and mark the severity of your pain on the pain scale at the bottom of the page.

<u>ACHE</u>	<u>BURNING</u>	<u>NUMBNESS</u>	<u>PINS & NEEDLES</u>	<u>STABBING</u>	<u>OTHER</u>
/////	BBBBBB	XXXXXXXX	ZZZZZZ	OOOO



NEXT GENERATION PHYSICAL THERAPY

I have indicated that Next Generation Physical Therapy (MAY/MAY NOT) leave appointment information on my voice mail.

The following people listed below may have access to my personal health information and/or

Communicate with medical staff regarding my healthcare treatment.

Coach's: _____

Athletic Trainers: _____

Others: _____

_____ Check here if you would not like anyone listed.

Patient information:

Name: _____

Address: _____

Phone number: _____

Date of Birth: _____

I acknowledge that I have been offered a copy (posted in lobby) of Notice of Privacy Policies dated September 2015.

X _____ Date: _____

Patient signature or legal guardian

For Staff Use Only

_____ Patient received notice, but refused to sign.

2800 South 2nd St.

Cabot, AR. 72023

(501)286-6059



Primary Care Physician		Referring Physician		Date of Injury	
PATIENT INFORMATION					
Patient Name		Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?	
Social Security Number		Date of Birth		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Physical Address, City, State and Zip Code					
Billing Address, City, State, and Zip Code					
Home Phone Number		Cell Phone Number		Email Address	
Employer Name				Employer Phone Number	
Employer Address, City, State, and Zip Code					
Insurance carrier Primary:				ID#	
Insurance carrier Secondary:				ID#	
Is this visit the result of a Workers' Compensation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If YES, did you file a Worker's Compensation Claim?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Is this visit the result of a Motor Vehicle Accident?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If YES, is there an attorney representing you?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
RESPONSIBLE PARTY					
Name: (Last, First, MI)		Phone Number		Social Security	Date of Birth
Address, City, State and Zip Code					
EMERGENCY CONTACT					
Name:			Phone Number:		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Next Generation Physical Therapy to release any information required of my insurance company to process and pay my claims.

Patient/Guardian Signature

Date

DO YOU HAVE, OR DID YOU EVERHAVE, ANY OF THE FOLLOWING?

Cardiovascular:

YES/NO

- Mitral Valve Prolapse
- High Blood Pressure
- Heart Disease from Childhood
- Heart Murmur
- Rheumatic Fever
- Use of Phen-Fen
- Pacemaker
- Vascular Graft
- Heart Valve Replacement
- Heart Attack
- Heart Surgery
- Congestive Heart Failure
- Angina (chest pain)
- Irregular Heart Beat
- Stroke
- Increased Cholesterol

Respiratory:

YES/NO

- Asthma
- Emphysema
- Tuberculosis
- Other

Endocrine/Hematologic/Oncologic/Immune:

YES/NO

- Diabetes
- Thyroid Disease
- Hemophilia
- Sickle Cell Disease
- Bleeding Tendency
- Anemia
- Cancer
- Radiation Therapy
- Chemotherapy
- HIV infection/AIDS
- Organ Transplant
- Blood Transfusion

GI/GU:

YES/NO

- Hepatitis (A,B,C,or other?)
- Kidney Dialysis
- Ulcers
- Sexually Transmitted Disease
- Denied Permission to give Blood

Musculo-Skeletal/CNS/Development:

YES/NO

- Joint Replacement
- Osteoarthritis
- Rheumatoid Arthritis
- Spinal Cord Injury
- Seizures
- Cerebral Palsy
- Mental Retardation
- Dementia

Psychological:

YES/NO

- Anxiety/Nervousness
- Depression
- Mental Health Treatment
- Eating Disorder

Social:

YES/NO

- Do you use Tobacco Products?
- Do you Drink Alcohol? Every Day? If so, how much?
- Do you use recreational drugs?

Medications:

Dosage:

Oral/Injection:

Frequency:

Reason:

<u>Medications:</u>	<u>Dosage:</u>	<u>Oral/Injection:</u>	<u>Frequency:</u>	<u>Reason:</u>

Have you had any falls in the last 12 months?

If so, how many:

Reason for fall:

NEXT GENERATION PHYSICAL THERAPY

PHOTO RELEASE FORM

Here at Next Generation Physical Therapy we like to be involved with the community and inform the community what we do on a regular basis. In doing so we use social media pages (Facebook, Twitter, Instagram, and YouTube). We would love to have your permission to use pictures and videos on these pages so we can demonstrate to the community the type of treatment we provide here.

I, the undersigned, do hereby grant permission to the Next Generation Physical Therapy to use the image of my child or myself, _____ . Such use includes the display or use of photographs taken of my child or myself for use in materials that include, Social media (Facebook, Instagram, Twitter).

I give unrestricted permission for my child or my self's image to be used in print and digital media. I agree that these images may be used by the Next Generation Physical Therapy for a variety of purposes and that these images may be used without further notifying me. I do understand that the child will not be identified in conjunction with any images without obtaining additional consent to do so.

Parent/individual signature _____ Date _____

Notice of Exclusions of Medicare Benefits

Explanation of Benefits for Outpatient

Physical Therapy Services

Medicare benefits for **Outpatient Physical/ Speech therapy** services have been combined for a total benefit of **\$ 1980.00 per calendar year.**

A separate per calendar year benefit of **\$1980.00 for Outpatient Occupational therapy** services has been provided by Medicare.

As a courtesy, Next Generation Physical Therapy will bill Medicare on your behalf. The therapy department will track your progress toward the annual therapy cap.

Medicare has created a provision for patients to receive therapy beyond the cap when it is medically necessary. If you ultimately require therapy in excess of what the annual cap will allow, your therapist will discuss this with you and whether you fit the criteria to receive therapy in excess of the annual cap.

By signing below, I acknowledge that I have been informed of the current Medicare benefits for outpatient Physical/Speech and Occupational Therapy.

Signed: _____ Date: _____

NEXT GENERATION
PHYSICAL THERAPY