

**PROGRESSIVE PHYSICAL THERAPY AND REHABILITATION**

129 W. Wilson St., Suite 202  
Costa Mesa, CA 92627  
Tel: 949.631.0125 Fax: 949.631.0127

894 W. Town and Country Road Building "F"  
Orange, CA 92686  
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**LOW BACK HISTORY**

**PATIENT INFORMATION**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

Gender:  Male  Female Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Best # to reach you?  Home  Work  Cell

Would you like to receive text/voicemail appointment reminders?  Yes  No

Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (optional) Emergency Contact Phone #: (\_\_\_\_) \_\_\_\_\_

Driver's License: \_\_\_\_\_ Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

- Employment Status (18):
- Presently working full duty at same job
  - Unemployed
  - Presently working full duty at different job
  - Retired
  - Presently working restricted duty at same job
  - Student
  - Presently working restricted duty at different job
  - Other
  - Employed, but presently not working due to my condition
  - Previously employed and receiving disability benefits due to my condition

Occupation:  Professional/Executive  White Collar/Secretarial  Tradesperson  Laborer  Homemaker  Other

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Date of Injury/Onset of Symptoms: \_\_\_\_\_ Place of Injury:  Work  Auto  Other

**INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Claim/Policy #: \_\_\_\_\_ Name of Primary Insured: \_\_\_\_\_

Group #: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_

Relationship: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Claim/Policy #: \_\_\_\_\_ Name of Primary Insured: \_\_\_\_\_

Group #: \_\_\_\_\_ Birthdate of Insured: \_\_\_\_\_

Relationship: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## HEALTH QUESTIONNAIRE

In general, would you say your overall health right now is:     Excellent     Very Good     Good     Fair     Poor

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

<b>Today, because of your back problem, do you or would you have any difficulty at all...</b>	<b>Unable to perform</b>	<b>Extreme difficulty</b>	<b>Quite a bit of difficulty</b>	<b>Moderate difficulty</b>	<b>A little bit of difficulty</b>	<b>No difficulty</b>
1. Performing any of your usual work, housework, or school activities?						
2. Performing your usual hobbies, recreational, or sporting activities?						
3. Performing heavy activities around your home?						
4. Bending or stooping?						
5. Lifting a box of groceries from the floor?						
<b>Does or would your back problem limit:</b>	<b>Yes, limited a lot</b>	<b>Yes, limited a little</b>	<b>No, not limited at all</b>			
6. Vigorous activities like running, lifting heavy objects, participating in strenuous sports?						
7. Moderate activities like moving a table, pushing a vacuum cleaner, bowling, or playing golf?						
8. Lifting or carrying items like groceries?						
9. Attending social events?						
10. Getting in and out of a chair?						

12. Please indicate the number of surgeries for your primary condition.     None     1     2     3     4+

13. How many days ago did the condition begin?     0-7 Days     8-14 Days     15-21 Days     22-90 Days     91 Days to 6 Mos.  
 Over 6 mos. ago

14. Are you taking prescription medication for this condition?     Yes     No

15. Have you received treatments for this condition before?     Yes     No *(If yes, please provide information below)*

Seen by:     Physical Therapist     Chiropractor     Medical Doctor     Other \_\_\_\_\_

When? \_\_\_\_\_

Tests done/date:     X-rays    Date: \_\_\_\_\_     CT Scan    Date: \_\_\_\_\_

MRI    Date: \_\_\_\_\_     Other \_\_\_\_\_

16. This is a statement other patients have made. ***“I should not do physical activities which (might) make my pain worse.”***  
Please rate your level of agreement with this statement below. (✓ response)

- Completely Agree
- Somewhat Agree
- Unsure
- Somewhat Disagree
- Completely Disagree

17. How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition?       At least 3 times a week       Once or twice per week       Seldom or never

19. Other health problems may affect your treatment. Please check (✓) any of the following that apply to you:

- |   |   |
|---|---|
| <input type="radio"/> Arthritis (rheumatoid / osteoarthritis)   | <input type="checkbox"/> Visual impairment (such as cataracts, glaucoma, macular degeneration)            |
| <input type="radio"/> Osteoporosis  | <input type="checkbox"/> Hearing impairment (very hard of hearing, even with hearing aids)                |
| <input type="radio"/> Asthma  | <input type="checkbox"/> Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis) |
| <input type="radio"/> Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema | <input type="checkbox"/> Kidney, bladder, prostate, or urination problems                                 |
| <input type="radio"/> Angina  | <input type="checkbox"/> Previous accidents   |
| <input type="radio"/> Congestive heart failure (or heart disease)   | <input type="checkbox"/> Allergies  |
| <input type="radio"/> Heart attack (Myocardial infarction)  | <input type="checkbox"/> Incontinence   |
| <input type="radio"/> High blood pressure   | <input type="checkbox"/> Anxiety or Panic Disorders   |
| <input type="checkbox"/> Neurological Disease (such as Multiple Sclerosis or Parkinson’s)                                       | <input type="checkbox"/> Depression   |
| <input type="checkbox"/> Stroke or TIA  | <input type="checkbox"/> Other disorders  |
| <input type="checkbox"/> Peripheral Vascular Disease  | <input type="checkbox"/> Hepatitis / AIDS   |
| <input type="checkbox"/> Headaches  | <input type="checkbox"/> Prior surgery  |
| <input type="checkbox"/> Diabetes Types I and II  | <input type="checkbox"/> Prosthesis / Implants  |
| <input type="checkbox"/> Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)                           | <input type="checkbox"/> Sleep dysfunction  |
|   | <input type="checkbox"/> Cancer   |

11. Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.      Weight: \_\_\_\_\_ lbs.

**Pain Assessment:**

Is pain a symptom:  No (If response is no, you are finished with your survey).  
 Yes (If yes, please complete the remain of the questions below)

Rate the level of pain you have had in the last 24 hours (*please circle response*):

None 0 1 2 3 4 5 6 7 8 9 10

Over the past month, how would you rate your pain when it was the best? (*please circle response*)

None 0 1 2 3 4 5 6 7 8 9 10

Over the past month, how would you rate your pain when it was the worst? (*please circle response*)

None 0 1 2 3 4 5 6 7 8 9 10

Is your pain constant?  Yes  No

Provide the percentage of time you experienced pain in the last 24 hours (*please circle response*):

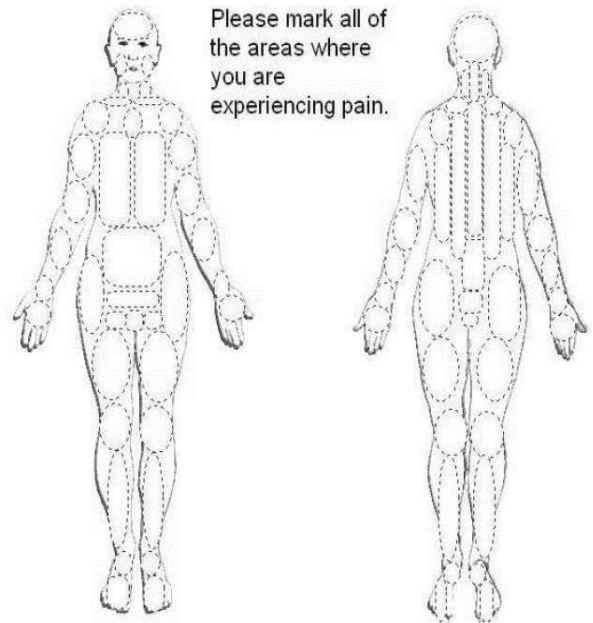
None 10% 20% 30% 40% 50% 60% 70% 80% 90%

# of days over the last week you experienced pain (*please circle response*): 1 2 3 4 5 6 7

# of weeks you have experienced pain: \_\_\_\_\_

Please select all that describes your pain and circle the intensity for each one selected:

Description of Pain	Intensity		
	Mild	Moderate	Severe
Throbbing			
Shooting			
Stabbing			
Sharp			
Cramping			
Gnawing			
Hot / Burning			
Aching			
Heavy			
Tender			
Splitting			
Tiring / Exhausting			
Sickening			
Fearful			
Punishing / Cruel			



# ***CONTINUITY OF CARE FORM***

We understand that many patients have a team of doctors working in conjunction with their medical care. To ensure continuity of care, we would like to be able to send treatment information and progress reports to your other MD's. By signing below, you give Progressive Physical Therapy and Rehab permission to release this information.

\_\_\_\_\_  
PATIENT NAME:

\_\_\_\_\_  
PATIENT SIGNATURE:

\_\_\_\_\_  
DATE:

REFERRING PHYSICIAN:

\_\_\_\_\_ phone # \_\_\_\_\_

FAMILY PHYSICIAN/INTERNIST:

\_\_\_\_\_ phone # \_\_\_\_\_

RHEUMATOLOGIST:

\_\_\_\_\_ phone # \_\_\_\_\_

RADIATION ONCOLOGIST:

\_\_\_\_\_ phone # \_\_\_\_\_

MEDICAL ONCOLOGIST:

\_\_\_\_\_ phone # \_\_\_\_\_

ORTHOPEDIC SURGEON:

\_\_\_\_\_ phone # \_\_\_\_\_

OTHER (please specify):

\_\_\_\_\_ phone # \_\_\_\_\_

Insurance Authorization Information – OFFICE USE ONLY				
Diagnosis:		Date:	Initials:	Spoke to:
Patient Co-Ins %:	Patient Co-Pay \$:	Deductible Start Amount \$:		Amount Met: \$
LIMITS	Visits Per Year:	Consec Days Per Year:	Amount Per Year:	Out of Pocket:
Visits are combined with: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Chiro <input type="checkbox"/> SLP <input type="checkbox"/> Acupuncture <input type="checkbox"/> Other			# Visits remaining:	Effective Date:
Billing Address:		City:	State:	Zip:
Authorization Phone #:			PT Auth. #	
Discussed Benefits with Patient:		Date: _____	Initials: _____	
Notes:				

**Patient Authorization, Release and Financial Responsibility**

I authorize treatment by the staff at Progressive Physical Therapy and Rehabilitation and authorize the release of information to other health professionals and to my insurance company. I authorize payment to be made directly to Progressive Physical Therapy and Rehabilitation. I do not hold Progressive Physical Therapy and Rehabilitation responsible for any incorrect or omitted information or for any changes in my future coverage. I also agree that I am responsible for the contract between myself and my insurance company. If for any reason my insurance company denies coverage and/or payment, I understand that I am financially responsible for the entire balance of my account and that my balance will be paid in a timely manner. I understand any co-payments and deductibles will be paid at the time of service. **I have read the above estimation of benefits from my insurance company and agree to verify this information by reading my insurance benefits book or contacting my insurance company.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Cancellation/No Show Policy**

To ensure that we are able to continue providing the highest quality of care and to help minimize patient waiting time, we require a 24-hour advanced notification for any appointments cancelled. If the patient fails to comply with this policy or fail to show up for the scheduled appointment, Progressive Physical Therapy will charge a \$45.00 fee for all appointments missed. This fee will be due at the beginning of the next scheduled visit.

Initials: \_\_\_\_\_

**Returned Checks**

Checks returned due to insufficient funds will be liable to a \$30 processing fee for the first occurrence. The second occurrence will be charged a \$50.00 fee and each additional payment must be made using a different form of payment, such as cash or credit card. Any unpaid balances beyond 60 days will be turned over to a collections agency.

Initials: \_\_\_\_\_

**Written Reports and Letters**

I understand that any report or letter beyond an initial evaluation report or a progress report will be subject to a \$50.00 fee.

Initials: \_\_\_\_\_

**Receipt of Notice of Privacy Practices Acknowledgment**

I acknowledge that I have read, or have had the opportunity to read, and understand the Notice of Privacy Practices that was provided for me.

Initials: \_\_\_\_\_

## **Progressive Physical Therapy and Rehabilitation**

894 W. Town and Country Road  
Building "F"  
Orange, CA 92868  
714.547.1140

129 W. Wilson St., Ste. 202  
Costa Mesa, CA 92627  
949.631.0125

### **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization except in instances required by law. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternate locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you feel that your privacy rights have been violated, you may file a written complaint at the address listed below. Under no circumstances will the fact that you have filed a complaint affect the services provided to you by Progressive Physical Therapy and Rehabilitation, Inc.

Progressive Physical Therapy and Rehabilitation  
129 W. Wilson St., Ste. 202  
Costa Mesa, CA 92627  
Attn: Privacy Officer  
949.631.0125  
Or Fax to 949.631.0127