Progressive Physical Therapy Plus

12665 Garden Grove Blvd Suite 603
Garden Grove, CA 92843
Phone 714*643*9012 Fax 714*643*9015

Patient Information

Last Name:_____ First Name:_____ MI: _____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:( )_____-_____ Work Phone:( )_____-_____ Cell Phone:( )_____-_____

Please indicate the best # to reach you: Home/Work/Cell Email:_____
Would you like text or email reminders for your appointments Yes___ No_____

Date of Birth:___/___/_____ Age:____ M/F:____ Marital Status:_____
Social Security:_____-____-_____(optional) Driver's License:_____
Occupation:_____ Employer:_____
Employer Address:_____ City:_____ State:_____ Zip:_____

Emergency Contact Phone Number: ( ) _____-_____

Last Name:_____ First Name:_____ Relationship:_____

Referring Physician:_____ City:_____ Phone:( )_____-_____
Family Physician:_____ City:_____ Phone:( )_____-_____
Date of Injury/Onset of Symptoms:_____ How did you hear about us?_____
Place of Injury: Work/Auto/Other State:_____ Employment Status:_____ Student: Y/N

Insurance Information

Insurance Company:_____ Phone Number:( )_____-_____
Claim/Policy #:_____ Group #:_____
Name of Primary Insured:_____ DOB:___/___/___ Relationship:_____

Secondary Insurance Company:_____ Phone Number:( )_____-_____
Claim/Policy #:_____ Group #:_____
Name of Primary Insured:_____ DOB:___/___/___ Relationship:_____

Have you received physical therapy in this calendar year? Yes No
If yes, when and how many treatments?_____

Have you had any injections for your current problem? Yes No If yes, Location:_____
Do you have any surgical implants (plastic, metal, etc…)? Please explain:_____

What are your goals for physical therapy?_____

Medications currently taking:_____
_____

Patient Signature:_____ **Date**:_____/_____/_____

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: □ PT □ OT □ Chiro □ SLP □ Acupuncture □ 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 understand that my visits have been pre-authorized by my Workers' Comp carrier and all payments will be made them. I understand that I will not be held financially responsible for any unpaid visits.

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 $25.00 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:_____

FOTO Patient Intake Survey
Medical / Neurological

Staff to Complete

PATIENT NAME: _____ Patient ID: _____

Gender: Male / Female Date of Birth: ____/____/____ Clinician: _____

Body Part _____ Impairment _____ Care Type _____

Payer Source: _____ *(ie: Preferred provider, HMO, WC, Medicare B)*

Date of Survey: ____/____/____

The following assessment will ask you about difficulties you may have with certain activities. It's an important part of your evaluation. It will help us:

- understand how your condition is affecting your activities, and
- develop treatment goals with you.

Please answer the questions with respect to the problem for which we are seeing you. Respond based on how you have been over the past few days.

Today, does or would your health problem limit:	**Yes, limited a lot**	**Yes, limited a little**	**No, not limited at all**
1. Vigorous activities like running, lifting heavy objects, sports?			
2. Walking more than a mile?			
3. Climbing several flights of stairs?			
4. Moderate activities like moving a table or pushing a vacuum cleaner?			
5. Lifting or carrying items like groceries?			
6. Bending, kneeling, or stooping?			
7. Going on vacation?			
8. Climbing one flight of stairs?			
9. Lifting overhead to a cabinet?			
10. Getting in and out of a chair?			

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

0 1 2 3 4 5 6 7 8 9 10
(None) (Pain as bad as it can be)

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 ☐ 15-21 ☐ 22-90 ☐ 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

16. 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

Patient Name: _____ Patient ID: _____

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

- ☐ Arthritis (rheumatoid / osteoarthritis)
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema
- ☐ Angina
- ☐ Congestive heart failure (or heart disease)
- ☐ Heart attack (Myocardial infarction)
- ☐ High blood pressure
- ☐ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
- ☐ Stroke or TIA
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Diabetes Types I and II
- ☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ☐ Pacemaker
- ☐ Seizures
- ☐ Visual impairment (such as cataracts, glaucoma, macular degeneration)
- ☐ Hearing impairment (very hard of hearing, even with hearing aids)
- ☐ Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- ☐ Kidney, bladder, prostate, or urination problems
- ☐ Previous accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Other disorders
- ☐ Hepatitis, Tuberculosis, HIV, AIDS, or other blood-borne condition
- ☐ Prior surgery
- ☐ Prosthesis / Implants
- ☐ Sleep dysfunction
- ☐ Cancer
- ☐ None of the above

18. Height (Required): _____ ft. _____ in. Weight (Required): _____ lbs.