

Rehab Management Physical Therapy
New Patient Enrollment Form
Clinic: G Rk Rw T Q M F

Patient Information

Name _____ Birthdate _____ Employer _____
Address (st) _____ Sex: M F Address _____
City _____ Marital Status: M S D W _____
Phone# _____ SS# _____ Work Phone# _____
Cell Phone# _____ Email _____ DL# _____
Referred By _____ Phone# _____ NPI _____ Date of Injury _____
Was Injury Accident Related: Yes / No Auto Related: Yes / No Employment Related: Yes / No Other: Yes / No
Explain _____ Prior Physical Therapy For This Incident: Yes / No
Are you currently receiving / received in the last 30 days Home Health from anyone for any procedure? Yes / No
Family Physician _____ Phone# _____
Relative (not living with you) _____ Phone# _____
Emergency Contact _____ Phone# _____

Responsible Party Information W/C Same As Above

Name _____ Employer _____ Birthdate _____
Address _____ Address _____ SS# _____
(street) _____
Phone # _____ Phone # _____ Relationship to Patient _____

Prescription Information

Pt ID# _____ Admit Date _____ Dx(ICD9) _____

RxA _____ Date Span _____ Aprvd By _____ Date _____ Sign _____ Auth _____
RxB _____ Date Span _____ Aprvd By _____ Date _____ Sign _____ Auth _____

Primary Insurance Information WC MC Ins Cash Auto Atty Other _____

Insured's Name _____ SS# _____ Birthdate _____
Ins Co Name _____ Phone# _____
Address _____ Contact Name _____
Date _____ Time _____
Group# _____ Policy# _____ Claim# _____ Payor# _____
Subscriber/relation _____ Eff Date _____ Network Name _____
HMO / PPO / POS / EPO / Other _____ Medicare – Open Home Health episode? Yes / No
Are we In Network? Yes / No Is insurance company Self Funded? Yes / No We bill POS Code "11"

In Network

Deductible \$ _____ Calendar Year? Yes / No Explain _____ Ded Met \$ _____ O/O/P \$ _____ Met \$ _____
O/V CoPay \$ _____ 97001 / 97002? Pays _____ % Patient Co-Ins _____ % Referral Required? Yes / No

Out of Network

Deductible \$ _____ Calendar Year? Yes / No Explain _____ Ded Met \$ _____ O/O/P \$ _____ Met \$ _____
O/V CoPay \$ _____ 97001 / 97002? Pays _____ % Patient Co-Ins _____ %
PreCert Required? Y / N PreCert Phone# _____ Max Vst Per Yr _____ Vsts used to Date _____
\$ Max for PT Per Yr \$ _____ Amt used to Date \$ _____ Is Ded Included? Y / N Is Max Payout / Allowable?
Plan Exclusions / Non-covered (ie, 97124-Massage, 97033-Ionto, Strapping/Taping, Supplies) _____

Auth/Ref# _____
Comments _____

My benefits have been explained to me. Patient Signature _____ Date _____

Rehab Management Physical Therapy
Medical History



Patient Name: _____ D/O/B _____

Do you now or have you ever had any of the following? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker / Surgical Implant |
| <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Open Wounds | <input type="checkbox"/> Current Infections | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Seizures | <input type="checkbox"/> Metal In Body |
| <input type="checkbox"/> Cancer / Tumor | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> CVA / Stroke |
| <input type="checkbox"/> Previous Fractures | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Previous Surgeries |
| <input type="checkbox"/> Hypersensitivity to Heat / Cold | | <input type="checkbox"/> Presently Pregnant |
| <input type="checkbox"/> Hepatitis (A, B, C) | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other(_____) |

Explanation & approximate date: _____

Are you presently taking medications? Yes / No

If yes, list medications & specify condition _____

Do you require assistance in completing this form? Yes / No

Patient / Guardian Signature

Date

Rehab Management
Social / Vocational Questionnaire



Patient Name: _____ Date: _____

The following is a list of questions designed to aid in your physical rehabilitation. They are not designed to embarrass or pry, merely to assess any needs you might have. The answers will be kept confidential. You do not have to answer any question or questions, at your discretion.

1. Do you currently have transportation to and from Physical Therapy? Yes / No
2. Do you currently have financial difficulties that would prohibit you from coming to Physical Therapy? Yes / No
3. Are you currently experiencing any anxiety or depression about or from Physical Therapy? Yes / No
4. Are you currently in need of any psychological counseling? Yes / No
5. Are you currently – please circle one of the following:
Employed Unemployed Retired-Date_____ Disabled-Date_____
6. Are you currently receiving, or in the last 30 days, have you received Home Health services from anyone for any type of procedure? Yes / No

If yes, please write Agency name, Phone number and Nurse name:

Patient / Guardian Signature

Date

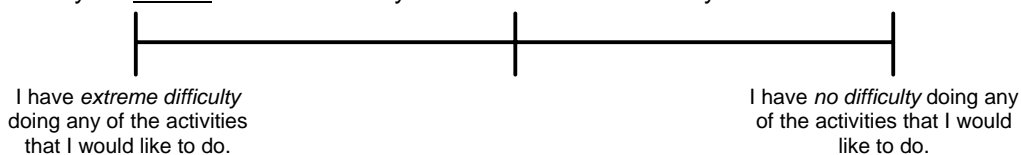
OPTIMAL INSTRUMENT

Patient Name: _____ Date: _____

Difficulty–Baseline - Evaluation

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all of the activities you would like to do, please mark an “X” at the point on the line that best describes your overall level of difficulty with these activities today.



23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. 12 2. 8 3. 13)

1. ____ 2. ____ 3. ____

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Patient Name: _____ Date: _____

Confidence–Baseline - Evaluation

Instructions: Please circle the level of confidence you have for doing each activity today.	Fully confident in my ability to perform	Very confident	Moderate confidence	Some confidence	Not confident in my ability to perform	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all the activities you like to do, please mark an “X” at the point on the line that best describes your overall level of confidence in performing these activities today:

