

Pt # \_\_\_\_\_ Valdosta Physical Therapy, Inc. (229) 247-5225

(Please Print... Fill out all items below and sign)

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

Patient: \_\_\_\_\_

Responsible Party (if a minor): \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Street Address: \_\_\_\_\_ Cell #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Sex:  M  F

Chief Complaint: \_\_\_\_\_ Date of onset: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Date of follow-up appt. with MD: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Single:  Married:  Widowed:  Separated:  Divorced:

Patient Social Security #: \_\_\_\_\_ Spouse Social Security #: \_\_\_\_\_

Patient Employed By: \_\_\_\_\_

Business Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Spouse/Parent: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you have medical insurance?  NO  YES

Name of primary insurance: \_\_\_\_\_

Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_ DOB Insured: \_\_\_\_\_

Name of Secondary Insurance (if any): \_\_\_\_\_

Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_ DOB Insured: \_\_\_\_\_

**Assignment of Insurance Benefits**

The undersigned hereby authorized the release of any information relating to all claims for benefits on behalf of myself and/or dependants. I further expressly agree and acknowledge that my signature on this document authorized my therapist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ to pay and hereby assign directly to Valdosta Physical Therapy, Inc. all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that insurance benefits, when received by and paid to Valdosta Physical Therapy, Inc. will be credited to my account with the above assignment.

\_\_\_\_\_  
(Authorized Signature of Subscriber)

\_\_\_\_\_  
(Date)

## MEDICAL HISTORY

Survey Date: \_\_\_\_\_

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

Reason for Referral: \_\_\_\_\_

### Current Condition

Height: \_\_\_\_\_ FT. \_\_\_\_\_ IN.

Weight: \_\_\_\_\_ LBS.

Pregnant? \_\_\_\_\_ (Y/N)

Currently on Medication? \_\_\_\_\_ (Y/N)

List Medications: \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_ (Y/N)

Per Day: \_\_\_\_\_ Per Week: \_\_\_\_\_

List Allergies: \_\_\_\_\_

Describe your general health: (choose one)

Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

Do you use any assistive devices? \_\_\_\_\_ (Y/N) Cardiovascular Fitness: (Choose One)

List Devices: \_\_\_\_\_ Aerobic Activity 3-5 days week

Do You Smoke Cigarettes? \_\_\_\_\_ (Y/N) Occasional Recreation activities at

Packs Per Day \_\_\_\_\_ least 4 times a month

\_\_\_\_\_ Sedentary Life-style

## HISTORY

Have you ever had any of the following? (Check all that apply)

<input type="checkbox"/> Anemia	<input type="checkbox"/> Headaches	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shortness
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> of Breath
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Low Blood Press.	<input type="checkbox"/> Stoke
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Metal Implants	<input type="checkbox"/> Swollen
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Ankles
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hernia.	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Other
<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Press.	<input type="checkbox"/> Rheumatoid arthritis	
<input type="checkbox"/> Fainting	<input type="checkbox"/> HIV	<input type="checkbox"/> Tuberculosis	List: _____
<input type="checkbox"/> Fractures	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Seizures	

List surgeries with date: \_\_\_\_\_

## OBJECTIVES:

Primary reasons for attending therapy: (check all that apply)

<input type="checkbox"/> Pain	<input type="checkbox"/> Activity Reduction
<input type="checkbox"/> Limited Motion	<input type="checkbox"/> Loss of Independence
<input type="checkbox"/> Weakness	<input type="checkbox"/> Unable to Work
<input type="checkbox"/> Injury	<input type="checkbox"/> Unable to do Household Tasks
<input type="checkbox"/> Surgery	<input type="checkbox"/> Unable to Play Sports or Recreations

What are your personal goals for therapy: (choose 4 that are most important)

<input type="checkbox"/> Decrease Pain	<input type="checkbox"/> Regain Mobility/Flexibility
<input type="checkbox"/> Learn Self-Care Techniques	<input type="checkbox"/> Increase Strength
<input type="checkbox"/> Resume/Improve Household Chores	<input type="checkbox"/> Increase Sitting tolerance
<input type="checkbox"/> Resume/Improve Gardening	<input type="checkbox"/> Increase Walking Distance/Speed
<input type="checkbox"/> Return to Work Activities	<input type="checkbox"/> Improve Posture
<input type="checkbox"/> Return to Sports	<input type="checkbox"/> Improve Sleep
<input type="checkbox"/> Improve Self-Care (dressing, hair)	<input type="checkbox"/> Improve Body Mechanics



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## **Valdosta Physical Therapy, Inc.**

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### **WORKMANS COMPENSATION POLICY**

We welcome you to our office and appreciate the opportunity to provide you with physical therapy services. The information below is designed to answer many of the questions most patients have regarding our billing policy.

Workmans Compensation usually pays 100%, but if for some reason they do not pay you will be responsible for all services rendered.

Our goal is to return you to the workplace as quickly as possible at the highest functional level available.

Please know that we are working under many of the same Worker's Compensation guidelines that you are. For instance, it is expected that you will report to your appointments here just as if this were your workplace. You are expected to be on time, complete your job duties (therapy), and call if for any reason you may be late. Absences are not tolerated just as if you were on your job.

Additionally, our responsibilities include that you will get the highest level of care available. Also, our communication with your physician, human resources director, and/or insurance carrier will be timely. All of this is to ensure your optimum health care and best interests.

If you have any questions, please do not hesitate to ask. Please read the statement below and sign.

I have read the above information and I understand these policies.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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## Valdosta Physical Therapy, Inc.

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### WORKERS COMPENSATION QUESTIONNAIRE

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

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

Please answer the following questions regarding your injury and its affect on your ability to work.

- 1) What was the date of the injury we are treating you for? \_\_\_\_\_
- 2) How were you injured? \_\_\_\_\_  
\_\_\_\_\_
- 3) What were your job duties at the time of your injury? \_\_\_\_\_  
\_\_\_\_\_
- 4) Were you able to continue working after your injury? \_\_\_\_\_
- 5) If you were unable to continue working, how long were you out of work? \_\_\_\_\_
- 6) Are you working now? \_\_\_\_\_
- 7) If you are working now are you doing the same job duties you were before your injury?  
\_\_\_\_\_
- 8) If you are working now but not the same job how are your job duties different than they were before your injury? \_\_\_\_\_  
\_\_\_\_\_
- 9) If you are not working now, why are you out of work? \_\_\_\_\_  
\_\_\_\_\_
- 10) If you are not working now, are you planning to return to the same job? \_\_\_\_\_
- 11) If you are not planning to return to the same job, what type of job are you planning to do Or wish to do? \_\_\_\_\_
- 12) Is there any other information regarding your ability to work or goals for returning to work That you feel would assist us in your physical therapy treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_