



EUGENE PHYSICAL THERAPY
PATIENT HISTORY QUESTIONNAIRE

PLEASE FILL OUT THIS FORM AS COMPLETE AS POSSIBLE. IT WILL ASSIST YOUR THERAPIST IN DEVELOPING A PLAN OF CARE FOR YOU. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK FOR ASSISTANCE. THIS INFORMATION WILL REMAIN CONFIDENTIAL UNLESS AUTHORIZED FOR RELEASE BY THE PATIENT.

NAME _____ DATE OF BIRTH: _____

OCCUPATION _____ HOBBIES: _____

DATE OF INJURY _____ PLEASE CIRCLE: SUDDEN ONSET GRADUAL ONSET

HAS THIS INJURY PREVENTED YOU FROM WORKING? YES NO IF YES, HOW LONG OFF WORK _____

WORK STATUS: AT THE **PRESENT TIME** I AM ABLE TO:

_____ Work without restrictions _____ Don't normally work outside the home
_____ Work the same job with restrictions _____ Homemaker
_____ Work a different job with restrictions _____ Retired
_____ Unable to work due to dysfunction _____ Other

IS AN ATTORNEY INVOLVED WITH THE CASE? YES NO

IF YES, ATTORNEY NAME: _____ PHONE: _____

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION?

_____ No other treatment _____ Massage Therapy _____ Chiropractor
_____ Physical/Occupational Therapy _____ Psychiatrist/Psychologist _____ Other: _____

LIST ALL PRESCRIPTION MEDICATION YOU ARE TAKING (Including injection and skin patches: _____

LIST ALL OVER-THE-COUNTER MEDICATIONS YOU ARE TAKING (Including vitamins and supplements):

PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED:

DATE	SURGERY/HOSPITALIZATION	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU CURRENTLY HAVING OR HAVE EXPERIENCED ANY OF THESE SYMPTOMS IN THE PAST 3 MONTHS?

_____ Fever _____ Chills _____ Night Sweats _____ Shortness of Breath
_____ Pins/Needles _____ Numbness _____ Skin Rash _____ Headaches
_____ Vision Problems _____ Hearing Loss _____ Bowel/Bladder Problem

NAME _____
 DATE _____ Initial Visit Discharge Visit

PROBLEM AREA (Please check one):

- Upper Extremity (A,D) Lower Extremity (B,F) Cervical/Thoracic (C,D) Lumbar (D,F) TMJ (C,E)

FUNCTIONAL INDEX

PART I: Answer all five sections in Part 1. Choose the one answer in each section that best describes your condition.

WALKING

- Symptoms do not prevent me walking any distance.
- Symptoms prevent me walking more than 1 mile.
- Symptoms prevent me walking more than 1/2 mile.
- Symptoms prevent me walking more than 1/4 mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

WORK

(Applies to work in home and outside)

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all (only light duty).
- I cannot do any work at all.

PERSONAL CARE

(Washing, Dressing, etc.)

- I can manage all personal care without symptoms.
- I can manage all personal care with some increased symptoms.
- Personal care requires slow, concise movements due to increased symptoms.
- I need help to manage some personal care.
- I need help to manage all personal care.
- I cannot manage any personal care.

SLEEPING

- I have no trouble sleeping.
- My sleep is mildly disturbed (less than 1 hr. sleepless).
- My sleep is mildly disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-5 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

RECREATION/SPORTS

(Indicate Sport if Appropriate _____)

- I am able to engage in all my recreational/sports activities without increased symptoms.
- I am able to engage in all my recreational/sports activities with some increased symptoms.
- I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
- I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
- I can hardly do any recreational/sports activities because of increased symptoms.
- I cannot do any recreational/sports activities at all.

ACUITY

(Answer on initial visit.)

How many days ago did onset/injury occur? _____ days

PART II: Choose the one answer that best describes your condition in the sections designated by your therapist.

A. UPPER EXTREMITY

CARRYING

- I can carry heavy loads without increased symptoms.
- I can carry heavy loads with some increased symptoms.
- I cannot carry heavy loads overhead, but I can manage if they are positioned close to my trunk.
- I cannot carry heavy loads, but I can manage light to medium loads if they are positioned close to my trunk.
- I can carry very light weights with some increased symptoms.
- I cannot lift or carry anything at all.

DRESSING

- I can put on a shirt or blouse without symptoms.
- I can put on a shirt or blouse with some increased symptoms.
- It is painful to put on a shirt or blouse and I am slow and careful.
- I need some help but I manage most of my shirt or blouse dressing.
- I need help in most aspects of putting on my shirt or blouse.
- I cannot put on a shirt or blouse at all.

REACHING

- I can reach to a high shelf to place an empty cup without increased symptoms.
- I can reach to a high shelf to place an empty cup with some increased symptoms.
- I can reach to a high shelf to place an empty cup with a moderate increase in symptoms.
- I cannot reach to a high shelf to place an empty cup, but I can reach up to a lower shelf without increased symptoms.
- I cannot reach up to a lower shelf without increased symptoms, but I can reach counter height to place an empty cup.
- I cannot reach my hand above waist level without increased symptoms.

B. LOWER EXTREMITY

STAIRS

- I can walk stairs comfortably without a rail.
- I can walk stairs comfortably, but with a crutch, cane, or rail.
- I can walk more than 1 flight of stairs, but with increased symptoms.
- I can walk less than 1 flight of stairs.
- I can manage only a single step or curb.
- I am unable to manage even a step or curb.

UNEVEN GROUND

- I can walk normally on uneven ground without loss of balance or using a cane or crutches.
- I can walk on uneven ground, but with loss of balance or with the use of a cane or crutches.
- I have to walk very carefully on uneven ground without using a cane or crutches.
- I have to walk very carefully on uneven ground even when using a cane or crutches.
- I have to walk very carefully on uneven ground and require physical assistance to manage it.
- I am unable to walk on uneven ground.

■ C. CERVICAL/TMJ

CONCENTRATION

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

HEADACHES

- I have no headaches at all.
- I have slight headaches which come less than 3 per week.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come 4 or more per week.
- I have severe headaches which come frequently.
- I have headaches almost all of the time.

READING

- I can read as much as I want without increased symptoms.
- I can read as much as I want with slight symptoms.
- I can read as much as I want with moderate symptoms.
- I cannot read as much as I want because of moderate symptoms.
- I can hardly read at all because of severe symptoms.
- I cannot read at all.

■ D. LUMBAR*/CERVICAL/UPPER EXTREMITY

DRIVING

- I can drive my car or travel without any extra symptoms.
- I can drive my car or travel as long as I want with slight symptoms.
- I can drive my car or travel as long as I want with moderate symptoms.
- I cannot drive my car or travel as long as I want because of moderate symptoms.
- I can hardly drive at all or travel because of severe symptoms.
- I cannot drive my car or travel at all.

LIFTING

- I can lift heavy weights without extra symptoms.
- I can lift heavy weights but it gives extra symptoms.
- My symptoms prevent me from lifting heavy weights but I manage if they are conveniently positioned. (e.g. on a table)
- My symptoms prevent me from lifting heavy weights but I manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

PAIN INDEX

Please indicate the worst your pain has been in the last 24 hours on the scale below



PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

IMPROVEMENT INDEX

Please indicate the amount of improvement you have made since the beginning of your physical therapy treatment on the scale below.



■ WORK STATUS (check most appropriate)

- 1. No lost work time
- 2. Return to work without restriction
- 3. Return to work with modification
- 4. Have not returned to work
- 5. Not employed outside the home

Work days lost due to condition: _____ days

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial: _____

■ E. TMJ

TALKING

- I can talk without any increased symptoms.
- I can talk as long as I want with slight symptoms in my jaws.
- I can talk as long as I want with moderate symptoms in my jaws.
- I cannot talk as long as I want because of moderate symptoms in my jaws.
- I can hardly talk at all because of severe symptoms in my jaws.
- I cannot talk at all.

EATING

- I can eat whatever I want without symptoms.
- I can eat whatever I want but it gives extra symptoms
- Symptoms prevent me from eating regular food, but I can manage if I avoid hard foods.
- Symptoms prevent me from chewing anything other than soft foods.
- I can chew soft foods occasionally, but primarily adhere to a liquid diet.
- I cannot chew at all and maintain a liquid diet.

■ F. LUMBAR*/LOWER EXTREMITY

STANDING

- I can stand as long as I want without increased symptoms.
- I can stand as long as I want, but it gives me extra symptoms.
- Symptoms prevent me from standing for more than 1 hour.
- Symptoms prevent me from standing for more than 30 minutes.
- Symptoms prevent me from standing for more than 10 minutes.
- Symptoms prevent me from standing at all.

SQUATTING

- I can squat fully without the use of my arms for support.
- I can squat fully, but with symptoms or using my arms for support.
- I can squat 3/4 of my normal depth, but less than fully.
- I can squat 1/2 of my normal depth, but less than 3/4.
- I can squat 1/4 of my normal depth, but less than 1/2.
- I am unable to squat any distance due to symptoms .

SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- My symptoms prevent me sitting more than 1 hour.
- My symptoms prevent me sitting more than 1/2 hour.
- My symptoms prevent me sitting more than 10 minutes.
- My symptoms prevent me from sitting at all.

* Lumbar questions adapted from Oswestry.



PATIENT DATA SHEET

Please complete this form in its entirety prior to your first visit. Also, please bring your insurance information and/or cards to our office at your first visit. **It is the patient's responsibility to notify our office of any changes to your information listed on this form.**

PATIENT INFORMATION

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME () _____ WORK () _____ CELL () _____

EMAIL: _____ PREFERRED WAY TO CONTACT YOU: HOME WORK CELL SEX: MALE FEMALE

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____
 MARRIED SINGLE WIDOWED SEPARATED OTHER

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

EMPLOYER NAME/ADDRESS: _____
STREET CITY, STATE ZIP

EMERGENCY CONTACT: _____ PHONE: _____
NAME/RELATION

THE ABOVE INFORMATION PERTAINS TO THE PATIENT ONLY.

IF THE PATIENT IS A MINOR, THEN THE RESPONSIBLE PARTY COMPLETES THE NEXT SECTION. IF THE PATIENT IS NOT A MINOR, THEN SKIP THE NEXT SECTION.

RESPONSIBLE PARTY INFORMATION

RELATION TO PATIENT MOTHER FATHER OTHER

NAME: _____ DATE OF BIRTH: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME () _____ WORK () _____ CELL () _____

EMPLOYER: _____ SOCIAL SECURITY NUMBER: _____

EMPLOYER ADDRESS: _____
STREET CITY STATE ZIP

INSURANCE INFORMATION ARE YOU AWARE OF YOUR BENEFITS FOR YOUR INSURANCE? YES NO

PRIMARY INSURANCE NAME: _____ INSURED NAME: _____

PRIMARY INSURANCE ADDRESS: _____ PHONE: _____

POLICY ID# _____ POLICY GROUP # _____ SEE COPY OF CARD

SECONDARY INSURANCE NAME: _____ INSURED NAME: _____

SECONDARY INSURANCE ADDRESS: _____ PHONE: _____

POLICY ID# _____ POLICY GROUP # _____ SEE COPY OF CARD

ACCIDENT INFORMATION: Was this injury the result of an accident? No Yes DATE OF ACCIDENT/INJURY: _____
 MOTOR VEHICLE ACCIDENT WORK RELATED OTHER

HIPAA: By signing this form I acknowledge that I have received a copy of the HIPAA "Notice of Information Practices" from Eugene Physical Therapy, LLC and understand it completely.

CONSENT: By signing this form, I agree and give my consent for Eugene Physical Therapy Services, LLC to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

Signature

Date

Patient Financial Policy

This is an agreement between Eugene Physical Therapy, LLC (creditor) and the Patient (debtor) named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient (debtor). The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us" and "our" refer to Eugene Physical Therapy, LLC.

By executing this agreement, you are agreeing to pay for all services and supplies that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, and any payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Required Payments: Any co-payments or co-insurance required by an insurance company must be paid at the time of service. We shall have the right to cancel your privilege to make charges against your account at any time and require that visits must be paid at the time of service.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay, deductible or co-insurance, you must pay that at the time of service. As contracted providers with your insurance company, we agree to accept the allowable amount (usual and customary) established by your insurance company. Although we may estimate what your insurance company may pay and the patient responsibility portion, it is the insurance company that makes the final determination of payment and eligibility.

Non-Contracted Insurance: Insurance is a contract between you and your insurance company. It is the patient's responsibility to verify if our office is a contracted or non-contracted provider. As a non-contracted provider, there is no adjustment or write-off for the difference between what we charge and what the insurance allows. You agree to pay any portion of the charges not covered by your insurance.

Primary Insurance: If possible, we will verify your insurance benefits and eligibility prior to your first appointment. It is the patient responsibility to be aware of your own benefits and eligibility. If your insurance company notifies us that they are waiting to receive the accident report form from you, the balance is automatically patient responsibility and we will begin collection procedures. As a courtesy to you, we will bill your primary insurance; however, if our office has not received payment after 120 days, the balance will become patient responsibility unless other arrangements are made with us.

Secondary Insurance: As a courtesy to you, we will bill your secondary insurance after your primary insurance has paid. If our office has not received payment from your secondary insurance after 120 days from the date first billed to your secondary insurance, the balance will become patient responsibility unless other arrangements are made.

Referrals/Prescription/Authorization: If your insurance company requires a referral, prescription or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral, prescription and/or pre-authorization may result in a lower payment, or no payment from the insurance company.

Workers Compensation: If your claim is in deferred status, we will ask for private medical insurance to bill if your claim is denied. We require approval/authorization by worker's compensation carrier prior to your initial visit. If your claim is denied and you do not have private medical insurance, you will be responsible for payment in full. If your claim is in litigation, we do require verification of this from your attorney and/or worker's compensation carrier.

Personal Injury /Motor Vehicle Accidents (MVA): If you are being treated as part of a personal injury lawsuit or claim, we may require verification from your attorney. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred in a personal injury case. If you have Personal Injury Protection (PIP) through your motor vehicle insurance, we will bill them as primary insurance and will bill your private health insurance when your PIP benefits are used up.

INSURANCE BENEFITS:

Patient Responsibility

Deductible

Copay / Approximate CoInsurance

