Physical Therapy Services of RI

Patient Information Sheet

Patient's Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone# _____ Work # _____ Cell# _____

Sex: _____ Birthdate: _____ Drivers Lic# _____ S.S.# _____

May we leave a message at your home? _____ May we contact you at work? _____

Patient's Employer: _____

Employer Address: _____

Occupation: _____

Spouse's Name: _____ DOB: _____

Spouse's Employer: _____

Source of referral: _____

Primary Care Physician's Name: _____

****

Insurance Information

Primary Insurance Carrier: _____

Name of Policy Holder: _____ DOB: _____

Insurance ID Number: _____

Secondary Insurance Carrier: _____

Name of Policy Holder: _____ DOB: _____

Insurance ID Number: _____

****

Were you injured on the job/motor vehicle accident? _____

If yes date of injury: _____

Name of insurance company: _____

Address: _____

Phone # _____ Claim# _____ Contact name: _____

is there an attorney involved? _____

Address & Phone # _____

Physical Therapy Services of RI

HEALTH QUESTIONNAIRE

NAME_____ DATE_____ FILE_____

The purpose of this questionnaire is to assist us in providing you quality care by obtaining a better understanding of your total health status. We would appreciate your completion of this questionnaire and your therapist will answer any questions during your examination. This questionnaire is considered a part of your confidential medical record.

Chief problem or complaint:_____

1. MEDICAL HISTORY - Please circle the following:

1. Yes No Do you have high blood pressure?
2. Yes No Do you have heart problems?
3. Yes No Do you experience frequent heart palpitations?
4. Yes No Do you have angina (chest pain)?
5. Yes No Do you have a heart murmur?
6. Yes No Do you have abnormal heart rate?
7. Yes No Do you experience chest pain with exertion?
8. Yes No Do you have a problem with shortness of breath?
9. Yes No Do you have asthma or allergies?
10. Yes No Do you have lung problems?
11. Yes No Do you have heartburn, stomach or intestinal upset?
12. Yes No Do you have a history of ulcers?
13. Yes No Have you experienced recent weight loss/gain?
14. Yes No Have you experienced recent loss of appetite?
15. Yes No Do you have any bowel and/or bladder problems (constipation, diarrhea, urgency to urinate)?
16. Yes No Do you have any sexual dysfunction?
17. Yes No Do you have thyroid problems?
18. Yes No Do you have diabetes?
19. Yes No Do you have low blood sugar?
20. Yes No Do you have or have you had cancer?
21. Yes No Do you have osteoporosis?
22. Yes No Do you have headaches?
23. Yes No Do you have frequent joint sprains, muscle strain?
24. Yes No Do you have unusual joint pain and swelling?
25. Yes No Do you have a history of fractures?
26. Yes No Do you have a history of neck/back pain?
27. Yes No Do you have a history of trauma?

Please turn over

2. OB/GYN

1. Yes No Have you had any complicated pregnancies?
2. Yes No Do you have dysmenorrhea (abnormal menstrual cycles)?
3. Yes No Have you had pelvic inflammatory disease?

3. SYMPTOMS

1. Yes No Do your arms or legs fall asleep frequently?
2. Yes No Are your hands or feet usually cold?
3. Yes No Do your arms or legs swell?
4. Yes No Do your arms or legs fatigue easily?
5. Yes No Do you have any numbness or tingling?
6. Yes No Do you have any weakness in your arms or legs?
7. Yes No Do you have any coordination problems?
8. Yes No Do you have difficulty walking?
9. Yes No Do you experience dizziness with a change in position (e.g. from lying down to standing)?
10. Yes No Do you experience vertigo (feeling of spinning)?
11. Yes No Do you frequently lose your balance?
12. Yes No Do you have a problem with falling?
13. Yes No Do you have episodes of blurred or double vision?
14. Yes No Do you wear contact lenses or glasses?
15. Yes No Do you have impaired hearing?
16. Yes No Do you have ringing in the ears?
17. Yes No Do you have fullness in the ears?
18. Yes No Do you have difficulty swallowing?
19. Yes No Do you experience hoarseness?
20. Yes No Do you have unusual dryness or fullness in the throat?

4. MEDICATIONS - (Please list all medications, dosage and purpose)

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

5. SURGERIES - (Please list all surgeries & approximate dates)

1._____
2._____
3._____
4._____

6. DIAGNOSTIC TESTS - (Please check tests for current problem only)

1.____X-rays 5.____MRI
2.____CT Scan 6.____Bone Scan
3.____EMG 7.____Blood Chemistry
4.____Myelogram 8.____Other (please list)

_____
_____

7. HAVE YOU SEEN ANYONE ELSE FOR YOUR CURRENT PROBLEM?

1.____Physician (M.D.)
2.____Physical Therapist
3.____Chiropractor
4.____Osteopathic Physician
5.____Podiatrist
6.____Dentist
7.____Other (please list)

_____
_____

Physical Therapy Services of RI

McGill Pain Questionaire [and Body Chart]

Name: Date:

There are many words that describe pain. Some of these are grouped below.
Please check any words that describe the pain you have these days.

1. ____ Flickering
____ Quivering
____ Pulsing
____ Throbbing
____ Beating
____ Pounding

2. ____ Jumping
____ Flashing
____ Shooting

3. ____ Pricking
____ Boring
____ Drilling
____ Stabbing
____ Lancinating

4. ____ Sharp
____ Cutting
____ Lacerating

5. ____ Pinching
____ Pressing
____ Gnawing
____ Cramping
____ Crushing

6. ____ Tugging
____ Pulling
____ Wrenching

7. ____ Hot
____ Burning
____ Scalding
____ Searing

8. ____ Tingling
____ Itchy
____ Smarting
____ Stinging

9. ____ Dull
____ Sore
____ Hurting
____ Aching
____ Heavy

10. ____ Tender
____ Taut
____ Rasping
____ Splitting

11. ____ Tiring
____ Exhausting

12. ____ Sickening
____ Suffocating

13. ____ Fearful
____ Frightening
____ Terrifying

14. ____ Punishing
____ Gruelling
____ Cruel
____ Vicious
____ Killing

15. ____ Wretched
____ Blinding

16. ____ Annoying
____ Troublesome
____ Miserable
____ Intense
____ Unbearable

17. ____ Spreading
____ Radiating
____ Penetrating
____ Piercing

18. ____ Tight
____ Numb
____ Drawing
____ Squeezing
____ Tearing

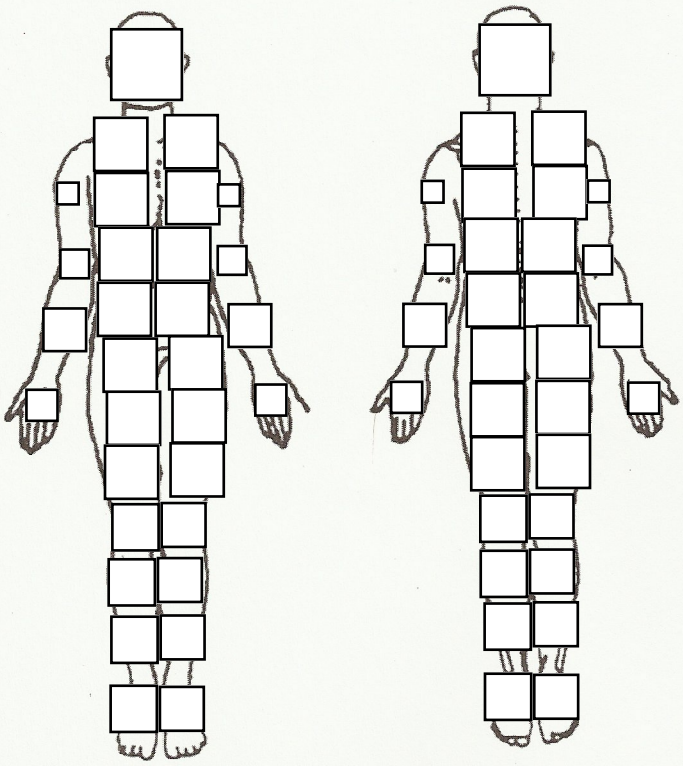
19. ____ Cool
____ Cold
____ Freezing

20. ____ Nagging
____ Nauseating
____ Agonizing
____ Dreadful
____ Torturing

Sleep: ____ Good
____ Fitful
____ Can't sleep

Comments: (Sleep)

Please mark on these drawings the areas where you feel your pain.



Accompanying Symptoms:
____ Nausea
____ Headache
____ Dizziness
____ Drowsiness
____ Constipation
____ Diarrhea

Activity:
____ Good
____ Some
____ Little
____ None

Food:
____ Good
____ Some
____ Little
____ None

Comments:

Comments: (Activity)

Comments: (Food)

What is your pain level on a scale of 0-10:
0 = Absense of Pain; 10 = Incapacitating Pain
0 1 2 3 4 5 6 7 8 9 10

300 Tower Hill Road Wickford, RI 02852 Ph. (401) 295-8500 Fx. (401) 295-8536 24 Salt Pond Road H-5 Wakefield, RI 02879 Ph. (401) 792-8500 Fx. (401) 792-8877

Physical Therapy
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Notification

Please be advised that our office needs a 24 hour notice of cancellation. There is an extensive waiting list, as well as a cancellation list. With your help, the care for other patients is our goal. Unfortunately, if we do not receive the required notification, a $25.00 fee will be charged.

Thank you for helping us improve our service to all our patients.

Michael S. Noonan, MS, PT

Please sign_____Date:_____

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* I understand that I agree to abide by the conditions of my insurance coverage and am responsible for all co-pay amounts at the time of service. I also agree to pay all deductible, co-pay and balance amounts at the time of billing.

* I also understand that it is my responsibility to have knowledge of the terms, benefits and restrictions of my health insurance plan and do not hold PHYSICAL THERAPY SERVICES OF RI, INC. liable for services not covered under my health insurance plan.

* I instruct such insurance company, agent, similar employee or third party coverage that said lien shall be fully satisfied first before I receive any moneys and that this instruction may not be revoked without first obtaining a release from PHYSICAL THERAPY SERVICES OF RI, INC.

* If my account is worker's compensation, I fully understand that if my claim is denied, I am responsible for payment of the full sum of my account.

* I hereby give an expressed priority agreement to PHYSICAL THERAPY SERVICES OF RI, INC. or its assignee, on any settlement, claim, judgement or verdict, and authorize and direct my attorney to pay PHYSICAL THERAPY SERVICES OF RI, INC. the full sum due for all services rendered including 1.5% monthly, 18% annually interest for balances past 30 days, prior to other disbursements of funds received by or on behalf of the attorney for me, and to further withhold all sums until such time as this lien is released by PHYSICAL THERAPY SERVICES OF RI, INC.

* I fully understand my debt to PHYSICAL THERAPY SERVICES OF RI, INC. is not conditional or contingent upon my claim against any third party or insurance company, and that this office policy is herein granted and accepted to accommodate me.

* I hereby accept full and total responsibility for payment of this account, including 1.5% monthly, 18% annually interest for balances past 30 days. I also understand that I will be responsible for any additional collection fees, attorney fees and court costs incurred to collect on balances past 90 days.

* I understand that by signing below, my signature is now on file for electronic billing purposes.

* I authorize payment of medical benefits, being made on my behalf, to PHYSICAL THERAPY SERVICES OF RI, INC. for services furnished to me by any physical or occupational therapist employed by PHYSICAL THERAPY SERVICES OF RI, INC.

* I authorize any holder of medical information, about me, to release to the health care holder and its agents, any information needed to determine these benefits payable for related services.

* I have been given the opportunity to receive and review a copy of the Patient Notice of Privacy Practices.

* I authorize P.T.S.R.I. to obtain any medical reports including diagnostic testing.

PATIENT'S SIGNATURE_____ DATE_____

PRINT NAME_____

WITNESS_____ DATE_____

Print Form | Submit by Email

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