LIGHTSEY PHYSICAL THERAPY

Client History Form

Date: ___/___/_____

Name: _____ **DOB:** ____/____/_____

Gender: M / F **Age:** _____years **Are you:** ___Right-handed ___ Left-Handed

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How would you classify your general health: ___Good ___Fair ___Poor

In terms of your general health, please circle ALL that apply:

Allergies	Anemia	Liver/Gallbladder Problem
Rheumatoid Arthritis	**Recent Fever**	Fibromyalgia
Metal Implants	**Ringing of the ears**	Asthma/Breathing Difficulties
Recent Headaches	**Recent Nausea/Vomiting**	Seizures/Epilepsy
Recent Vision Changes	Heart Attack	**Recent Dizziness/Fainting**
Sexual Dysfunction	**Cancer**	**Recent change in bowel/bladder habits**
Osteoarthritis	Skin Abnormalities	**Pain with Cough/Sneeze**
Heart Palpitations	Osteoporosis	Smoking History
Chest Pain/Angina	Hernia	Pacemaker
Stroke/TIA	Depression	High/Low Blood Pressure
Physical Abnormalities	Surgeries	Diabetes I or II
Hypoglycemia	Polio	**Unexplained Weight Loss/Gain**
Night Pain	Intolerance to Cold/Heat	Pregnancy (currently)
Urine Leakage	Recent Fractures	**Recent Unexplained Fatigue**
Kidney Problems	Heart Disease	**Numbness/Tingling in Hip/Buttocks Area**
Parkinson's Disease	COVID-19	Infectious Disease (TB, hepatitis etc.)

Is there any other information regarding your medical history or are there any factors that may complicate your ability to participate in therapy that we should know about? _____

_____

Have you had any falls in the last 12 months? ___ Yes ___ No

If yes, please describe the nature of the fall: _____

If yes, please describe if an injury occurred: _____

Have you had any surgeries? ____ Yes ____ No **If yes, please provide type and date:** _____

_____

Please list any medications you take to include dosage and frequency: (list can be attached)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Occupation: _____ **Presently Working:** ____ Yes ____ No

If yes, ____ Full Duty ____ Limited Duty: Restrictions: _____ # of days off work: _____

Please circle all job duties that apply to your occupation:

Sitting	Computer Work	Bending	Heavy Lifting	Traveling
Reaching	Crawling	Twisting	Pushing/Pulling	Walking
Standing	Gripping/Pinching	Other: _____		

What is your current living arrangement? ___ Alone ___ Spouse ___ Partner ___ Family ___ Other: _____

Does your home have stairs? ___ Yes ___ No **If yes, # of stairs:** _____ **Handrail?** ___ Yes ___ No___

Please circle any of the below devices you use:

Cane	Walker/Rollator	Manual Wheelchair	Electric Wheelchair
Glasses	Hearing Aid(s)	Other: _____	

Describe the current problem that sent you to Physical Therapy: _____

_____

Date of next Doctor's Visit: ___/___/_____ **When did your symptoms start:** ___/___/_____

How did your symptoms start? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

What are your goals for PT? _____

Please list anyone else you are seeing for your symptoms: _____

Please circle any of the below clinical tests you have undergone for your symptoms:

Biopsy	Blood Tests	Bone Scan	CT Scan	Doppler Ultrasound
EEG	EKG	EMG	MRI	Myelogram
NCV	Spinal Tap	Stress Test	X-ray	Other: _____

Indicate either "*yes*" or "*no*" as to whether each of the following activities is difficult:

Sleeping through the night: Yes No
Putting on or taking off clothes: Yes No
Maintaining a position for a period of time: Yes No
Getting into/out of: bed, chairs, shower, car: Yes No
Reaching: overhead, forward, downward, behind back: Yes No
Gripping: holding tools or opening jars: Yes No
Picking up small objects: Yes No
Sitting: Yes No
Standing: Yes No
Job Related Activities: Yes No

Balancing on both feet: Yes No
Walking on differing surfaces: Yes No
Lifting: Yes No
Carrying: Yes No
Bending/Kneeling/Squatting: Yes No
Driving a vehicle: Yes No
Caring for a child or another adult: Yes No
Housework/Yardwork: Yes No
Recreational Activities: Yes No
Other: _____

How would you describe your pain?

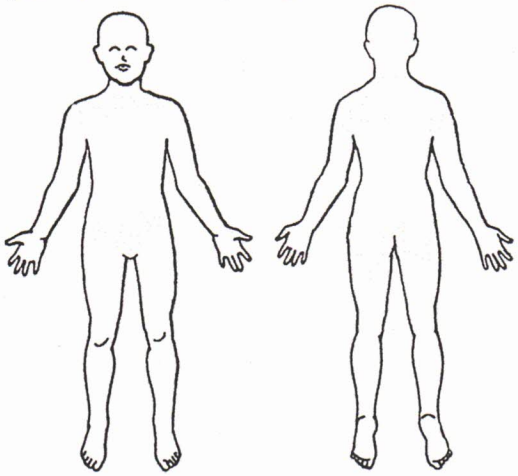
____ Constant ____ Come and go ____ Ache ____ Deep ____ Superficial
____ Dull ____ Sharp ____ Shooting ____ Burning ____ Numbness/Tingling

When is your pain the worst? ____ Morning ___ During the day ___ at night ___ with activity ____ at rest

On a scale of 0 (no pain) to 10 (unbearable pain requiring hospitalization), how would you rate your pain:

___/10 currently ___/10 at its worst ___/10 at its best ___/10 on average

Please mark the location(s) of your pain on the body diagram below:



I consent to receive outpatient rehabilitation therapy services as deemed necessary. I am aware that the practice of rehabilitation therapy is not an exact science and I acknowledge no guarantees have been made to me regarding treatments, results, or outcomes. In conjunction with my care, I consent to allow the use of filming devices for purposes of enhancing my care and I consent to allow transmittal of such images to me and/or my treating physician via email or test.

Signature of Patient or Guardian: _____ **Date:** ___/___/_____

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Medical Assignment of Benefits & Financial Policy

Please read and initial each of the following. Sign and date at the bottom.

Lightsey Physical Therapy is honored to be a part of your rehabilitation process and believes communication regarding our financial policy assists in providing you the best care possible. We will contact your insurance provider to obtain your current benefit coverage. However, insurance companies will not guarantee medical benefits or payment over the phone. Information gathered can only be used as a guideline.

1. I understand I have medical insurance which, when billed on my behalf, will (should) pay for my visits. This process may take several weeks/months. At that time, my insurance company will determine and pay for services according to my insurance plan benefits. _____ initial

2. I understand it is my responsibility, and agree, to pay all copays, co-insurance, deductibles, and/or cash pay estimated amounts at the time of service. _____ initial

3. I understand it is my responsibility to pay my account balance in full if at any point my physician and I elect to continue my therapy services past my approved period. _____ initial

4. I understand a copy of my explanation of benefits (EOB) will be sent to me by my insurance provider when the claims are processed. _____ initial

5. I understand it is my responsibility to pay all uncovered services within 30 days after my insurance has paid their portion. _____ initial

6. I understand if for any reason my insurance provider does not pay for the covered services within 90 days of the services provided, I will assume responsibility for the total amount owed. _____ initial

7. I understand if my account balance is not paid within 30 days from the date of my final statement, a $50 collection fee and other fees allowable by law will be added to my account. _____ initial

8. I understand if my account balance is not paid within 30 days from the date of my final statement, my account may be referred to a collection agency. _____ initial

9. I thereby assign all medical benefits to Lightsey Physical Therapy. _____ initial

10. I authorize Lightsey Physical Therapy to release my medical information to insurance companies, physicians, attorneys and to all other pertinent parties involved in my care or claim. _____ initial.

11. I understand any returned check will result in a nonrefundable administrative fee of $25.00. _____ initial.

I have read and understand this document and all of my questions have been answered to my satisfaction.

Patient/Guardian Signature: _____ Date: ___/___/_____

Patient Name (print): _____

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Patient Responsibilities/Consent

Please read and initial each of the following. Sign and date at the bottom.

1. It is the patient's responsibility to update their insurance information, address and contact information for the clinic's records. Failure to do so will result in the patient becoming responsible for all charges. _____ initial

2. It is the patient's responsibility to notify the therapist if they have been seen at another facility for physical therapy, hand therapy or speech therapy. _____ initial

3. It is the patient's responsibility to notify the therapist if their treatment is the result of an auto accident or if they were injured at work or school. _____ initial

4. It is the patient's responsibility to keep follow up appointments as scheduled. The individualized therapy program prepared for the patient requires the patient's commitment and attendance on a consistent basis to achieve optimal improvement and results. Failure to show for appointments can result in a delay of the patient's plan of care and/or discharge of services. _____ initial

5. It is the patient's responsibility to notify the office 24 (business) hours prior to a scheduled appointment if they are unable to keep the appointment. Failure to do so will result in a **$50.00** no show/late cancellation fee which must be paid prior to the next scheduled visit. _____ initial

6. I understand I have the right to refuse any treatments or procedures to the extent permitted by law. I understand the information from any medical record(s) maintained by this facility may be used for educational, administrative and/or facility approved purposes during which my identity will not be revealed. _____ initial

7. I understand if I do not see my physical therapist for two weeks or miss three appointments, the physical therapist may discharge my plan of care. Once I have been discharged, I understand I will need a new physician's referral/order for any further treatment and will undergo a new evaluation. This is in compliance with Texas State Law. _____ initial

8. I hereby authorize my rehab consultant to receive my records related to my injury/care. _____ initial

9. I have been provided the opportunity to review the Lightsey Physical Therapy "Notice of Privacy Practices." This document contains a description of the uses and disclosures of my healthcare information, and my rights regarding this information. Lightsey Physical Therapy displays the "Notice of Privacy Practices" in the clinic reception area. I understand Lightsey Physical Therapy has the right to change its "Notice of Privacy Practices" and that if changes are made, a revised copy of the notice will be posted in the reception area. I also understand if I have questions, or wish to receive a copy of the "Notice of Privacy Practices" I may contact the clinic. _____ initial

10. If you are a representative of the patient, check the scope of your authority to act on the patient's behalf:
___Power of Attorney ___Guardian ___Parent ___Executor of Legal Rep ___Other _____

I have read and understand the above information. All of my questions have been answered to my satisfaction.

Patient/Guardian Signature: _____ Date: ___/___/_____
Patient Name (please print): _____

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Authorization for Release of Patient Information

Patient Name: _____ Phone Number: _____

Other Names Used: _____ DOB: ___/___/_____ SS#: _____-_____-_____

Address: _____

I, the undersigned, authorize the release of the information specified below from the medical record(s) of the above-named patient.

_____ Release to: Lightsey Physical Therapy
2651 Boonville Road, Suite 115
Bryan, Texas 77808
Phone: (979) 446-0422
Fax: (979) 446-0433

_____ I hereby authorize Lightsey Physical Therapy to release information to (i.e. doctor(s), family, emergency contact):

_____

_____

_____

_____

_____

I specifically authorize the use and disclosure of the following PHI (select type and note the period of time you are requesting).

___ History and Physical _____

___ Radiology Reports _____

___ Verbal Communication regarding health care

___ Other _____

___ Operative Reports _____

___ Office Notes _____

___ Medications _____

___ Emergency Records _____

I understand I may revoke this consent at any time except to the extent that action has already been taken in reliance on it.

Patient or Guardian Signature: _____ Date: ___/___/_____

Printed Name: _____ Relationship to patient: _____

Falls Efficacy Scale

Name:_____ Date:_____

On a scale from 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you do the following activities without falling?

Activity:	**Score:** 1 = very confident 10 = not confident at all
Take a bath or shower	
Reach into cabinets or closets	
Walk around the house	
Prepare meals not requiring carrying heavy or hot objects	
Get in and out of bed	
Answer the door or telephone	
Get in and out of a chair	
Getting dressed and undressed	
Personal grooming (i.e. washing your face)	
Getting on and off of the toilet	
Total Score	

A total score of greater than 70 indicates that the person has a fear of falling

Adapted from Tinetti et al (1990)