

Patient Medical History

Name: _____ **Date:** _____

Birthdate: _____ Age: _____ Height: _____ Weight: _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Have you had treatment for this problem before? Yes No

Date symptoms began? _____

Is this problem the result of (check all that apply)

Car Accident Work Accident Other: (please specify) _____

Are you left/right hand dominant? Right Left

Are you/could you be pregnant? Yes No

Do you exercise/play sports? Yes No Type/Frequency _____

PAST MEDICAL HISTORY: (Please Check Any/All of the Following that Apply)

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Dysfunction	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> Arthritis Type _____	<input type="checkbox"/> DVT/Blood Clots	<input type="checkbox"/> Kidney Dialysis	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> STD
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Gallbladder Problems	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Gout	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bleeding/Bruising	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> MRSA/Staph Infection	<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Cancer Type _____	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Ulcers Type _____
<input type="checkbox"/> Colon Polyp	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Peripheral Vascular Disease	
<input type="checkbox"/> Congestive Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Polio	
<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Psychological Problems	
<input type="checkbox"/> Depression	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Pulmonary Embolism	
<input type="checkbox"/> Other: _____			

Medication History List the names of ALL medications that you take with or without a prescription

Pharmacy Name: _____ Phone Number: _____

Name of Medication	Dosage	Reason for Taking

ALLERGIES Please describe any current or past allergic reactions

Drug Allergy	Reaction	Treatment for Reaction

I have no allergies

Past Surgical History

Previous Surgeries	Hospital	Year
<input type="checkbox"/> Arthroscopy	_____	_____
<input type="checkbox"/> Joint Replacement	_____	_____
<input type="checkbox"/> Bone/Joint Reconstruction	_____	_____
<input type="checkbox"/> Spine	_____	_____
<input type="checkbox"/> Trigger Finger Release	_____	_____
<input type="checkbox"/> Carpal Tunnel Release	_____	_____
<input type="checkbox"/> Other Surgery/Hospital Stay	_____	_____
<input type="checkbox"/> Previous Steroid Injections	_____	_____
<input type="checkbox"/> I have not had surgery or been hospitalized		

Social History

Do you smoke? Yes No Have you smoked in the past? Yes No

How long have you smoked? _____ # Packs a day/brand: _____

Do you drink alcohol? Yes No How many drinks a month? _____

Do you have a history of drug/alcohol abuse? Yes No

Family History

Please check the box of all of the following problems your blood relatives (i.e. parents, sibling, grandparent) have had:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis Type _____ | <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer Type _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sudden Death |
| <input type="checkbox"/> Other _____ | | |

REVIEW OF SYSTEMS

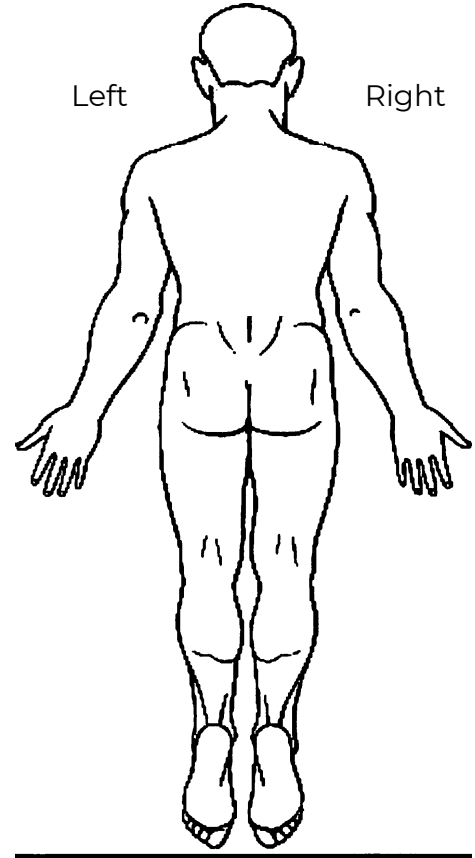
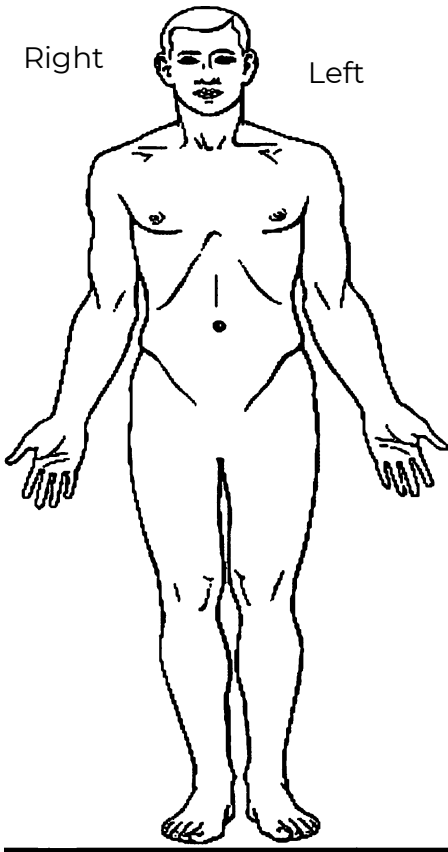
Please check any/all you have experienced in the past month. Be sure to notify your doctor if you have experienced any of the following.

- | | | | |
|--|---|---|--|
| <p>General</p> <input type="checkbox"/> Fever/Chills
<input type="checkbox"/> Weight Change
<input type="checkbox"/> Hormone problems
<input type="checkbox"/> Other
<input type="checkbox"/> None | <p>Gastrointestinal</p> <input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Heartburn/Acid Relief
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Other
<input type="checkbox"/> None | <p>Eyes</p> <input type="checkbox"/> Glasses/Contacts
<input type="checkbox"/> Cataracts
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Other
<input type="checkbox"/> None | <p>Cardiovascular</p> <input type="checkbox"/> Chest Pain
<input type="checkbox"/> Palpitations
<input type="checkbox"/> Fluid/Swelling in Extremities
<input type="checkbox"/> Other
<input type="checkbox"/> None |
| <p>Respiratory</p> <input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Other
<input type="checkbox"/> None | <p>Neurological</p> <input type="checkbox"/> Headaches
<input type="checkbox"/> Numbness
<input type="checkbox"/> Tingling
<input type="checkbox"/> Seizures
<input type="checkbox"/> Weakness
<input type="checkbox"/> Other
<input type="checkbox"/> None | <p>ENT/Mouth</p> <input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Ear Pain
<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Hard of Hearing
<input type="checkbox"/> Other
<input type="checkbox"/> None | <p>Endocrine</p> <input type="checkbox"/> Painful Urination
<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Incontinence
<input type="checkbox"/> Other
<input type="checkbox"/> None |
| <p>Hematologic/Lymphatic</p> <input type="checkbox"/> Anemia
<input type="checkbox"/> Blood Problems
<input type="checkbox"/> Clotting Disorder
<input type="checkbox"/> Lymph Problems
<input type="checkbox"/> Other
<input type="checkbox"/> None | <p>Skin</p> <input type="checkbox"/> Rashes
<input type="checkbox"/> Lumps
<input type="checkbox"/> Other
<input type="checkbox"/> None | <p>Psychological</p> <input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression
<input type="checkbox"/> Mood Swings
<input type="checkbox"/> Other
<input type="checkbox"/> None | |

Name: _____

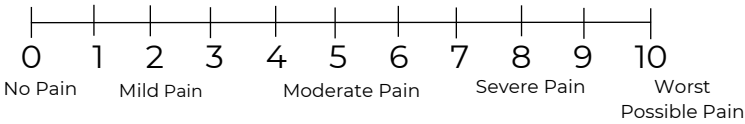
Date: _____

Please mark an "X" on the body part(s) where you have pain, an "O" on the body part(s) where you have numbness.

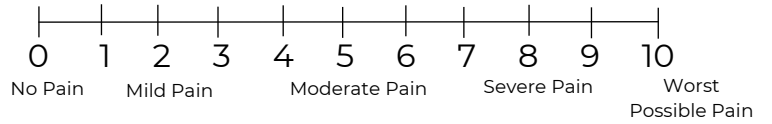


Select a number to indicate typical level of pain

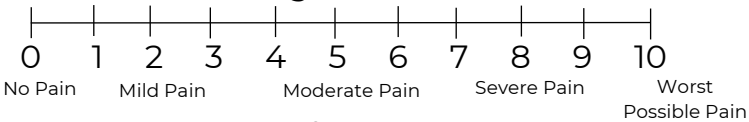
Neck



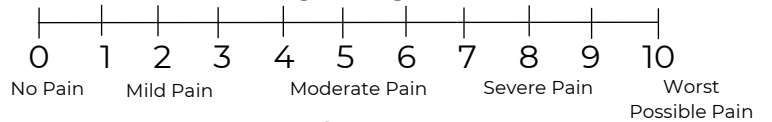
Back



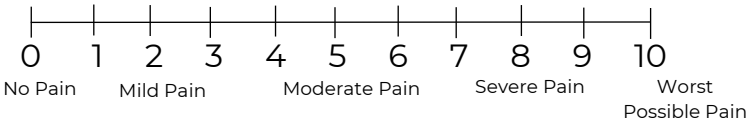
Right Arm



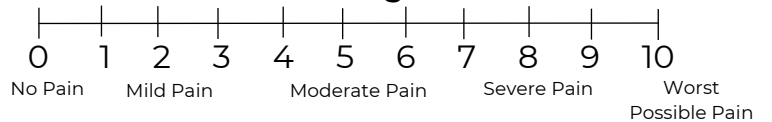
Right Leg



Left Arm



Left Leg



PATIENT INFORMATION

Account # _____	Home Telephone # _____
Patient Name _____	Work Telephone # _____
Social Security Number _____	Cell Telephone # _____
Address _____	Patient Sex _____
City, State & Zip Code _____	Date of Birth _____ Age _____
FOR MEDICARE PATIENTS ONLY Do you currently reside in a Skilled Nursing Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Contact Name & Phone _____
Employment/ Student Status: <input type="checkbox"/> Full time employed <input type="checkbox"/> Full time student <input type="checkbox"/> Part time employed <input type="checkbox"/> Part time student <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	Relationship to Patient: _____
Referring Physician: _____	Employer Name & Address _____
Family Physician: _____	Occupation: _____
Patient Smoking Status: <input type="checkbox"/> Current Every day Smoker <input type="checkbox"/> Current Some day Smoker <input type="checkbox"/> Smoker, current status Unknown <input type="checkbox"/> Never Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Unknown if ever Smoker	Email Address (please print): _____
Ethnicity of Patient: <input type="checkbox"/> Hispanic Origin <input type="checkbox"/> Non-Hispanic Origin <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to Answer	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other Spouse's Name: _____
	Race of Patient: <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/ African American <input type="checkbox"/> Native Hawaiian/ Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to answer
	Patient's preferred language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
In compliance with the American Recovery and Reinvestment Act of 2009 (ARRA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.	

Financially Responsible Person (if different from above)

Full Name	Social Security Number _____
Address	Home Telephone# _____
City, State & Zip Code	Work Telephone# _____
Date of Birth	Cell Telephone# _____
Employer Name	Relationship to the patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other

Insurance Company Information

Primary Insurance Company Name		Secondary Insurance Company Name	
Address, City, State & Zip		Address, City, State & Zip	
Policy Holder	Date of Birth	Policy Holder	Date of Birth
Policy Holder Employer	Policy Holder SSN	Policy Holder Employer	Policy Holder SSN
Policy Number	Group Number	Policy Number	Group Number
Relationship to the Patient (check one) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other		Relationship to the Patient (check one) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other	

Appointment Information:

Patient Name _____ **Account #:** _____

Physician Name _____

Who may we thank for referring you? _____

Body area being seen for today: _____

Problem? Yes No
Injury? Yes No
Work Injury Yes No
Auto Accident Yes No

Date problem began: _____
Date of injury: _____
Date of injury: _____
Date and State of accident: _____

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to AVALA, for anesthesia and orthopedic surgical services provided to me. I fully understand that payment for services is not contingent upon recovery, and this does not relieve me of my primary obligation to pay.

Signature: _____ **Date:** _____

Medicare Patients

If you are covered by Medicare, please read, and sign the following:

In Medicare cases, AVALA, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, co-insurance, and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature: _____ **Date:** _____



Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

Employer: _____ Phone: _____

Covered Benefits: As a courtesy, we will verify and file your claim with your insurance carrier, however we cannot guarantee payment. You are responsible for payment of any deductible, co-payment/coinsurance, and any non-covered services as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. If your insurance company denies any part of your claim or if you or your physician elect to continue therapy past your allowed/approved visits, payment will be expected from you. Verification is only an explanation of benefits based upon information that we received from your insurance carrier. It is not a guarantee of payment. Please contact your insurance carrier directly to confirm your individual benefits for Physical Therapy services.

Co-Payments: Co-payments and Co-insurance amounts must be paid at each visit according to your insurance contract. Please plan accordingly. We accept cash, checks and credit cards (Visa or Master Card).

Attendance Policy: Your therapist allocates a specific amount of time for your appointment to meet the needs of your rehabilitation program. We understand that there are times when you must miss an appointment, but request that you give us 24-hour notice. Please schedule a make-up appointment as soon as possible to help meet your rehabilitation goals. So that we may provide attentive care to each of our patients, please be aware that if you arrive more than 15 minutes later than your scheduled time, you may be asked to reschedule your appointment.

I have read the above statements. It is my understanding that I am financially responsible to **AVALA** for the services provided to me or my dependent. I authorize my insurer to pay any benefits directly to **AVALA**. I agree to pay the full amount of all charges incurred by the above-named patient that are not covered by my insurance provider.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. When an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five-dollar (\$25) fee; this will not be covered by your insurance company.

Patient Signature Date

Guarantor's Signature Date

Medical Release: I hereby authorize **AVALA** to release my medical records to physicians, insurance companies, and other social agencies as necessary. I also authorize AVALA to obtain any portion of my medical record from another institution that is deemed medically necessary during my treatment. **Initial** _____

Consent to Provide Treatment: I hereby authorize **AVALA** through its appropriate personnel to perform upon me or the above-named patient appropriate physical therapy assessment and treatment procedures relating to my diagnosis. **Initial** _____



ePrescribing

AVALA is in the process of implementing ePrescribing in each of our offices.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

The benefit to you:

- >Less confusion over handwritten prescriptions or unclear phone calls
- >Reduced possibility of medical errors
- >Less chance of adverse drug reactions
- >Fewer trips to drop off at the pharmacy
- >A safer, faster, easier way to get your prescription filled

Patient Consent

I agree that AVALA may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Patient's Signature

Date



Accident Questionnaire

Patient: _____ Date of Birth: _____

Insured's Name: _____ Relationship to Insured: _____

Policy #: _____ Group Number: _____

Reason for Today's Visit: _____

Were you injured in a MOTOR VEHICLE ACCIDENT? Yes No

Did your injury take place while you were working? Yes No

Other? _____

Date of Accident/Injury: _____

Length of pain or problem _____

Where/When/How? _____

Patient's Signature

Date



PAIN MANAGEMENT AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I **break this Agreement, my doctor will stop prescribing these pain-control medicines.**

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use the below pharmacy for filling prescriptions for all pain medications.

Pharmacy Name: _____

Address: _____

Phone Number: _____

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale or any other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if required by my doctor to determine my compliance with the program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medication to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this documentation has been given to me.

This agreement is entered into on this _____ day of _____

Patient Signature: _____

Physician Signature: _____

Witnessed by: _____