# PATIENT INFORMATION (PLEASE PRINT)

**Foothills Physical Therapy Center**

4011 Chapman Hwy Suite J Knoxville TN 37920 Phone 865-573-6458

**Legal Name**: First_________________________MI____Last___________________________________SSN:______________________

Nickname_____________________________ Occupation ________________________

Birth Date (mm/dd/yyyy):_______ _____ _______ Sex: Marital Status: Married ☐ Single ☐ Other: _________________

**Permanent Billing Address**: _____________________________________________City:___________________________State: _________

Zip Code____________ email__________________________________ Home Ph _____________________Cell:__________________

**Financially Responsible Person (*if other than patient):*** First_______________________MI___ Last _______________________________

SSN:______________________ Relationship_______________ Birth Date________________ Phone Number______________________

Referring MD (who sent you here):_________________________Primary Care MD_____________________________Ph__________________

Would you like for us to send your Physical Therapy Evaluation to your Primary Care MD? ☐ Yes ☐ No

Date of your Last visit to your referring physician (mm/dd/yyyy) ______________ Date of your Next MD scheduled visit:___ ______

Have you seen a chiropractor, or a speech, occupational or physical therapist in the last 12 months? ☐ Yes ☐ No.

If yes, how many visits? [ ]. Some insurance policies limit the maximum of visits covered per year.

**Is the injury or condition that you seek treatment for related to?**

Employment ☐ yes ☐ no Auto accident ☐ yes ☐ no Other accident ☐ yes ☐ no _

**When did your injury/condition occur or start?** _____________ _____________________________________

**Would you like for us to submit your claims to your:**

Health Insurance[ ] Medicare Part B[ ] Workers Compensation [ ] Auto Insurance [ ] Other______________________________

**If the primary health insurance subscriber is someone other than you, please supply the following information:**

Subscriber Name: First_________________________MI____ Last_______________________________Relationship_______________

DOB (mm/dd/yyyy): _________________ If Tricare, Sponsor ID#:________________________________

**How Did You Hear About Us?**

Physician[ ] Insurance[ ] HealthGrades[ ] Google[ ] I'm a returning patient[ ] Friend/Family[ ] Other________________________

**For Workers Compensation Claims only:**

Employer:_____________________________Business Phone:__________________________Supervisor_____________________________

Case Manager's Name**:**________________________________________ Phone_____________________________________________

## Patient Health Questionnaire

Name__________________________________________Age______Occupation ___________________________

If you are a student are you employed: ( ) full time ( ) Part-time Job ( ) Not employed

Job Duties________________________________________________________________________________________

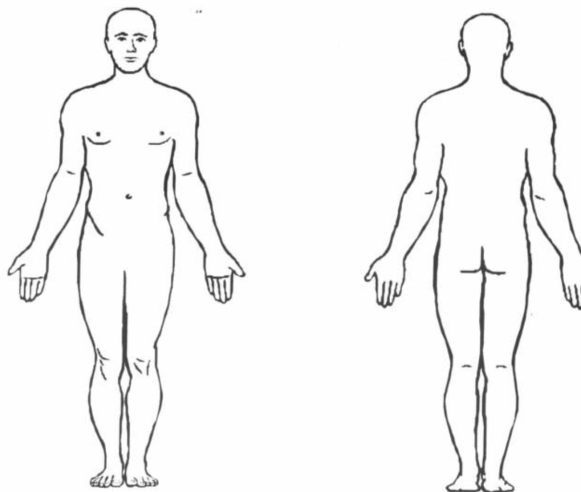
Describe the problem(s) for which you seek treatment_____________________________________________

_____________________________________________________________________________________________

How did your symptoms begin______________________________________________________________

When did your symptoms start?_____________________

*Indicate where you have pain or other symptoms*



What describes the nature of your symptoms?

( ) Sharp ( ) Shooting
( ) Dull ache ( ) Burning
( ) Numb ( ) Tingling

How often do you experience your symptoms?
( ) Constantly (76-100% of the day)
( ) Frequently (51-75% of the day)
( ) Occasionally (26-50% of the day)
( ) Intermittently (0-25% of the day)

Indicate the average intensity of your symptoms:

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
0 1 2 3 4 5 6 7 8 9 0

Have you ever had this problem before? ________

Briefly state previous treatment, if any:________________________________________________________

_____________________________________________________________________________________________

Have you had any X-rays, CAT scans, MRIs, or other diagnostic tests for your recent injury? Yes___No___. If yes, please explain the findings, as you understand them:_________________________________________________

_____________________________________________________________________________________________

Please give us a complete list all the medicines that you currently or regularly take:__________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Current activity level (hobbies, sports, recreation, etc):_____________________________________________

_____________________________________________________________________________________________

Activities wishing to return to:_____________________________________________________________

_____________________________________________________________________________________________

Is there anything else you think I should know about your general health? Please explain and, if necessary, we can talk about it.__________________________________________________________________________

_____________________________________________________________________________________________

**Past Medical History**

Have you experienced any of the following?

**Yes** **No**

[ ] [ ] **Orthopedic Surgery** ___________________________________________________________

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| **Heart Disease:** | | | | | |
| | | Congestive Heart Failure (CHF) | | | Valvular Disease |
| | | High Blood Pressure | | | Stents |
| | | Heart Attack | | | Arrhythmia |
| | | Atherosclerotic Disease | | | Coronary Artery Bypass |
| | | Angioplasty | | | Angina |
| | | Do you have a Pacemaker? | | | |
| **Vascular Disease:** | | | | | |
| | | Chronic Obstructive Pulmonary Disease (COPD) | | | Respiratory Distress Syndrome |
| | | Emphysema | | | Recent Pneumonia |
| | | Peripheral Artery Disease | | | Stroke/TIA |
| | | Blood Pressure Meds | | | Chronic Bronchitis |
| | | Diabetes | | | Hypertension |
| | | Asthma | | | |
| **General Medical Conditions:** | | | | | |
| | | Arthritis (rheumatoid/osteoarthritis) | | | Osteoporosis |
| | | Allergies | | | Anxiety or Panic Disorders |
| | | Neurological Disease (such as MS or Parkinson's) | | | Kidney, Bladder, Prostate or Urination Problems |
| | | Headaches | | | Previous Accidents |
| | | GI Disease (ulcer, hernia, reflux, bowel, liver, gall bladder) | | | Visual Impairment (cataracts, glaucoma, macular degeneration) |
| | | Depression | | | Incontinence |
| | | Back Pain (neck pain, low back pain, degenerative disc disease | | | Hearing Impairment |
| | | Hepatitis/AIDS | | | Sleep Dysfunction |
| | | Prior Surgery | | | Prosthesis/Implants |
| | | Cancer | | | |

Explain_____________________________________________________________________________

____________________________________________________________________________________

Other Disorders_______________________________________________________________________

**In Case of Emergency Contact**:

_________________________________________________________________Relationship:__________________

Home Phone:_______________________ Work Phone ___________________________Cell:_______________________

Signed________________________________________ Date__________________

## GENERAL INFORMATION

Our clinical staff includes:

- Amy Gregory Myers, Licensed Doctor of Physical Therapy
- Ryan Dulling, Licensed Doctor of Physical Therapy
- Meghan Hart, Licensed Physical Therapy Assistant

While your care may be with one of the individuals listed above, it is possible that all may be involved in your physical therapy treatment. We also have part-time physical therapists, physical therapy assistants and rotating physical therapy students that may assist in your care under the supervision of the physical therapists. Please feel free to discuss your concerns with your physical therapist. You have the right to refuse any treatment. For the protection of everyone, we ask if you bring family members or friends with you, please ask them to wait in the lobby. If it is necessary for someone to be with you during treatment, please discuss with your physical therapist.

## FINANCIAL RESPONSIBILITY

*(Available in our office and on our website)*

I understand and commit to the following:

- I will pay my co-pay, deductible and co-insurance at the time of service.
- I will provide the most current and accurate insurance information and notify Foothills of changes promptly.
- I understand that I am fully responsible for all balances that insurance does not cover.
- I request that payment of benefits, (including Medicare, any other government sponsored program, private insurance and any other health plan) be made to Foothills Physical Therapy and Sports Medicine.

I have received and understand Foothills Physical Therapy's Financial Policies Form.

_______________________________________________ ______________________

Signature of Financially Responsible Person Date

## NO SHOW and CANCELLATION POLICY

Consistent attendance is very important to your rehabilitation! **PLEASE GIVE 24 HOURS NOTICE IF YOU MUST CANCEL.** If you do not give a 24 hour notice, you may be charged a **$20.00** administrative fee. *

**If you No Show or cancel without proper notice 3 times, discharge from the practice may be required.***

_____________________________________________ ______________________

Signature of Patient or Legal Guardian Date

**Any contract between Foothills Physical Therapy and a medical payer that differs from the above stated policy will take precedence.*

**Foothills Physical Therapy Center**

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGED

I have been given an opportunity to review, ask questions about and understand Foothills Physical Therapy's Notice of Privacy Practices.

*(Available in our office and on our website www.foothillspt.us)*

_______________________________________________ _______________

Signature of Patient or Legal Guardian Date

## DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:______________________________ Relationship:___________________

Name:______________________________ Relationship:___________________

Name:______________________________ Relationship:___________________

Name:______________________________ Relationship:___________________

## COMMUNICATION PREFERENCES

What is your preferred method for us to contact you regarding appointments, your care and billing?

Home Phone Cell Phone

Would you like reminders for all your appointments? Please select one.

None Text Voicemail E-mail

_______________________________________________ _______________

Patient or Legal Guardian Signature Date