LINCOLN PHYSICAL THERAPY
AND SPORTS REHAB, LLC

Name _____ Social Security # _____ Sex M ___ F ___

Address _____ City, State _____ Zip Code _____

Date of Birth _____ Home Phone _____ Cell _____ Marital Status: S___ M___ D___ W___

E-Mail Address _____

Employer Name _____

Employer Address _____ Employer Phone #_____

Emergency Contact: Name/Phone # _____

If Married, Name of Spouse _____ Spouse's Employer _____

Spouse's Social Security Number _____ Spouse's Phone # _____

IS YOUR VISIT RELATED TO WORKERS COMPENSATION / 3RD PARTY LIABILITY / MOTOR VEHICLE? Yes ____ No ____
If "no" skip to Private Health Insurance Section below. If "yes", please circle related case: Work Comp / Liability / Motor Vehicle

Date of Injury _____ Where/How injury occurred _____

Employer/Carrier Name _____ Phone # _____

Address _____

Case Manager/Employer Contact/Attorney Name _____

Address _____ Phone # _____ Claim # _____

PRIVATE HEALTH INSURANCE:
HAVE YOU RECEIVED ANY OF THE FOLLOWING TREATMENT DURING YOUR CURRENT INSURANCE PLAN YEAR?
Physical Therapy? Yes ____ No ____ Home Health? Yes ____ No ____ Chiropractic Care? Yes ____ No ____

If yes to any, please specify name of facility and number of visits to each _____

_____

Primary Insurance (circle one): BC/BS Coventry Midlands Choice UHC Medicare Medicare Replacement Medicaid Other

Other Insurance _____

Secondary Insurance _____

If insured is other than patient (ie: spouse, parent, etc.)**:**

Name _____ DOB _____ Relationship _____ Phone _____

AUTHORIZATION: By signing this form, I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered. I also understand that I am responsible for payment of my medical bills regardless of the type of insurance coverage I have.
Lincoln Physical Therapy & Sports Rehab, LLC will bill your insurance on your behalf and make all reasonable efforts to obtain payment. **Finance Charge:** A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the items was added to the account. This charge will be computed at the rate of 1.25% or an annual percentage rate of 15%. **No Show Fee:** A fee of $25.00 will be charged for any missed appointment or appointments cancelled less than 4 business hours prior to your scheduled appointment time.

Signature of Patient/Parent/Legal Guardian _____ Date _____

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Referral Information

Patient Name _____ Date _____

Why did you choose us? (Primary Reason for Coming Here)

___ **Recommended by Friend/Family member** Name _____

___ **Recommended by Physician/Physician assistant** Name _____

___ **Recommended by Nurse/Nurse practitioner** Name _____

___ **Recommended by Employer** Name _____

___ **Recommended by Coach/Trainer** Name _____

___ **Other** _____

Please help us and let us know where you may have seen or heard our ads. Check all that apply.

___ Sign/Banner: Location _____
___ Church Bulletin _____
___ Lincoln Orthopedic Center Magazine
___ White Pages
___ LincolnPT.com website
___ Whitepages/Yellowpages.com
___ Internet Search Engine
___ Facebook
___ Other website _____
___ Other
___ Facebook
_____

Medical Information

Family Physician _____

Referring Physician if not noted above _____

LINCOLN PHYSICAL THERAPY
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PHYSICAL THERAPY PATIENT QUESTIONNAIRE

Patient Name: _____ **Today's Date:** _____

DOB: _____ **Age:** _____

Occupation: _____

Are you currently working: Yes / No **What percent of your workday do you Sit?** _____ **Stand?** _____

Are you a tobacco smoker? Never / Former / Current **If former or current tobacco smoker** - Packs/Day _____

Are you, or could you be, pregnant: Yes / No

Do you exercise at least 3 days per week? Yes / No

PAST MEDICAL HISTORY

Have you ever been told that you have or had the following (circle Yes or No):

Cancer	Yes	No	Heart Disease	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No	Osteoarthritis	Yes	No
Ulcers	Yes	No	Liver Disease	Yes	No	Rheumatoid Arthritis	Yes	No
Stroke	Yes	No	Osteoporosis	Yes	No	Hepatitis (A, B or C)	Yes	No
Allergies	Yes	No	Fibromyalgia	Yes	No	HIV	Yes	No
Type _____			Angina/Chest Pain	Yes	No	Thyroid problems	Yes	No
Asthma	Yes	No	Lung Disease (COPD)	Yes	No	Pacemaker/Debrillator/etc.	Yes	No

In the past 3 months, have you experienced any of the following?:

Dizziness	Yes	No	Change in appetite	Yes	No	Bowel/bladder changes	Yes	No
Headaches	Yes	No	Numbness/tingling	Yes	No	Unexplained weight loss	Yes	No
Depression	Yes	No	Fever/chills/sweats	Yes	No	Pain w/coughing/sneezing	Yes	No
Nausea/vomiting	Yes	No	Difficulty swallowing	Yes	No			
Falls/poor balance	Yes	No	Increased pain at night	Yes	No			

Past Surgical History (surgery & date) or Other Issues Not Listed Above: _____

_____

_____

_____

Current Medications (current list can be given to front desk to copy instead of writing here): _____

_____

_____

Preferred spoken language: _____ **Visually impaired?** Yes / No **Hearing impaired?** Yes / No

Please indicate your learning preference (circle): Demonstration / Written materials / Both

Please rate your level of agreement with this statement: "I should not do physical activities which might make my pain worse."
Completely Disagree / Somewhat Disagree / Unsure / Somewhat Agree / Completely Agree

PHYSICAL THERAPY PATIENT QUESTIONNAIRE

PRIMARY COMPLAINT

What date (approximately) did your present pain start? _____

How did your pain start? _____

Are your symptoms currently (circle one): Getting better / About the same / Getting worse

What treatments have you received for this problem so far? _____

_____

What makes your symptoms better? _____

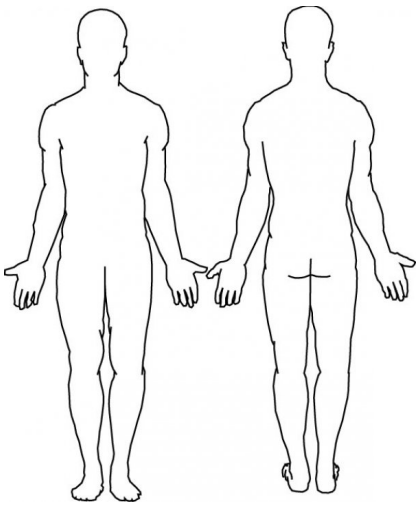
What makes your symptoms worse? _____

Have you had an x-ray, MRI or other imaging study for this problem? Yes / No

If yes, what type of imaging? _____ **Where were they taken** _____

Have you had similar symptoms in the past? Yes / No **If so, when?** _____

BODY DIAGRAM: Please mark the areas where you feel pain on the chart below.



Ache

Shooting Pain

Pins & Needles or Numbness & Tingling

Sharp Pain

Please mark the type and location of your pain on the pictures.

Pain Scale: On this scale from 0-10, please circle the number which best represents your pain:

At worst, my pain is:	No pain	0	1	2	3	4	5	6	7	8	9	10	**Worst pain imaginable**
Currently my pain is:	No pain	0	1	2	3	4	5	6	7	8	9	10	**Worst pain imaginable**
At best, my pain is:	No pain	0	1	2	3	4	5	6	7	8	9	10	**Worst pain imaginable**

Please circle the number below which best represents your overall average level of function:

Cannot do anything	0	1	2	3	4	5	6	7	8	9	10	Able to do everything

How are you able to sleep at night (circle)? Fine Moderate difficulty Only with Medication

Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem:

1. _____
2. _____
3. _____

What are your personal goals for therapy at this time? _____

_____

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New Patient Consent to the Use & Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Name _____ Date of Birth _____

I, _____, understand that as part of my health care, Lincoln Physical Therapy and Sports Rehab, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment. I understand that this information serves as;

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

Lincoln Physical Therapy and Sports Rehab, LLC will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions you must make your request in writing in the space below. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance upon this consent. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Lincoln Physical Therapy and Sports Rehab, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should they change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

_____

Due to HIPAA rules, if you would like your spouse, family member, or friend to have access to your account or health information, you will need to list their names and connection to you below:

_____

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operation, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and ( ) accept ( ) decline the terms of this consent.

Patient Signature _____ Date _____

If you are signing as the patient's representative:

Patient Representative (Please Print Name) _____

Patient Representative Signature _____

Describe your authority _____