Action Therapy
acupuncture & physical therapy

PATIENT REGISTRATION

Please fill out all *applicable* sections.

(Provide the receptionist with an official ID, insurance card(s), and prescription as necessary.)

Patient Information	**(Please provide an official ID to the receptionist - **ALL INFO REQUIRED!**)**			
First Name:	**Last Name:**	Middle Initial:	**Date:**	
Address:		**City:**	**State:**	**Zip:**
Birth Date:	**SSN:**	**[ ] Male [ ] Female**	[ ] Single [ ] Married	
Tel 1:	Tel 2:	**Email:**		
Chose Clinic Because:	**Referred By:** [ ] Insurance Plan [ ] Family [ ] Friend [ ] Former Patient [ ] Website: _____ [ ] Street Sign [ ] Close to Work/Home [ ] Dr: _____ [ ] Other: _____ *Please provide any additional info about how you heard about us:*			

In Case of Emergency	**(**ALL INFO REQUIRED!**)**	
Name of Local Friend or Relative (Not living at same address):		
Relationship to Patient:	**Tel 1:**	Tel2:

Insurance Information	(Please provide your insurance card to the receptionist)	
Primary Insurance Name:	ID #:	Group/Policy #:
Subscriber's Name (If different):		Birth Date:
Patient's Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other: _____		
Secondary Insurance Name:		
Subscriber's Name (If different):		
Patient's Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other: _____		

Work Information	(Required for work injury cases)	
Employer:	Work Tel:	Ext:
Address:	Employment Status: [ ] Working [ ] Disabled (__Total __Temporary) [ ] Not Employed [ ] Retired [ ] Student (__P/T __F/T)	

Auto or Work Injury Claim	(Please provide your insurance information for backup)		
Insurance Name: [ ] Auto: _____	[ ] Labor & Industries: _____		
Adjuster/Claim Manager:	Tel:		Ext:
Address:	City:	State:	Zip:
Claim #:	Accident Date:	Cause:	

Attorney Information	(Only complete if you are working with a lawyer for medical benefits)		
Attorney Name:	Law Firm:	Tel:	
Address:	City:	State:	Zip:

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PATIENT REGISTRATION

Referral Information (If applicable, please provide your prescription to the receptionist.)			
Primary/Referring Physician Name:	Tel:	Fax:	
Address:	City:	State:	Zip:
Do you have a follow up appointment with this physician? __Yes __No	If yes, when?:		

Payment Information (**ALL INFO REQUIRED!**)

I am paying by **CASH, CHECK, CREDIT** and would like a:

[ ] 30% discount by paying at the time of service. [ ] Payment plan. Fees may apply.

I have **INSURANCE** and would like to:

[ ] Have you deal directly with them. I will assign my benefits to you. Fees may apply.

My coinsurance/copay is: $_____ My deductible is: $_____

(If you don't know this information, call the "800" number on the back of your insurance card. The front desk can assist you.)

[ ] Get a 30% discount by paying the entire bill at the time of service. I'll get reimbursement on my own. (Ask for details.)

I have an **ATTORNEY** and would like to:

[ ] Get a 30% discount by paying up front. I'll get reimbursed after my case settles.

[ ] Wait until my case settles before paying. I will complete the "Attorney Lien" form. Fees may apply.

Credit Card on File (SAFE & SECURE. I understand I will be notified of all charges.)			
[ ] Visa [ ] MC [ ] AMEX [ ] Discover	Card #:		
Name on Card:	Exp Date:	CVV Code:	
Billing Address:	City:	State:	Zip:

Assignment of Benefits (Required for insurance patients)

I hereby authorize payment directly to ACTION THERAPY by my insurance company or other third party for services rendered. This is a direct assignment of my rights and benefits under this policy. I understand that I am financially responsible for all charges not paid by my insurance. I also understand that all payments made directly to me are to be forwarded to ACTION THERAPY. A copy of this assignment shall be considered as effective and valid as the original for all dates of services rendered. ACTION THERAPY may deposit checks issued under my name. I authorize the release of any medical or other information pertinent to my case for the purpose of processing claims and securing payment of benefits. I authorize the use of this signature on all insurance submissions.

Initial: _____

I hereby declare that the information provided is as complete and accurate as possible to my knowledge. I authorize my insurance benefits be paid directly to ACTION THERAPY and any outstanding charges be billed to the credit card on file. I understand that I am financially responsible for any balance. I also authorize ACTION THERAPY to release any information required to process my claims.

_____ _____ _____

Participant/Guardian Printed Name **Signature** **Date**

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POLICIES & AGREEMENTS

Important Company Policies for a Successful Relationship

Initial All Boxes

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.

☐ **Late Policy "10-minutes"**
Being late by more than 1 0 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**
If you wish to change or cancel an appointment we require a minimum *24-hour advance notice.* Anything less will result in a *$10* fee charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere *$10* fee. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **Copays are due upon arrival.**
If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

☐ **No-shows are bad.**
If you fail to show for an appointment without notice all future appointments will be removed and a *$10 fee* assessed to your account. You may re-schedule appointments again on a •first come, first serve basis".

☐ **Cell phones must be shut OFF or silent.**
We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or tum off. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you.**
Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

☐ **Financial Hardship**
If you are experiencing financial difficulties and are unable to afford the cost of our services we have a “Financial Hardship Form" which may be filled-out. If you quality for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

☐ **Important Notice from the Federal Government:**
“It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments ... even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's- Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply.

☐ **Consent to Treat**
I give consent to be evaluated and treated by the providers at ATI. I understand the possible risks and side-effects.

☐ ***Medicare Patients Only***
Medicare will only pay for the services that it determined to be reasonable and necessary under section 1862 (a) (1) of the Medicare law. Even through my physician has authorized and ordered physical therapy services and has determined it be reasonable and necessary, I understand there is a possibility Medicare may still deny payment. **I agree to be personally and fully responsible for payment should the services be denied. I also certify that I am not currently enrolled in any *Medicare home health program* or programs that may interfere with reimbursement for the services rendered.**

We look forward to building a successful relationship with you that lasts a lifetime!

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POLICIES & AGREEMENTS

WAIVER OF LIABILITY, INDEMNITY, AND INFORMED CONSENT AGREEMENT FOR SERVICES RENDERED

The undersigned ("Participant") for and in consideration of the granting of permission for Participant to willingly, voluntarily, understandingly engage in the activity of receiving treatments, education, procedures, exercises, devices, items, products and/or services at Action Therapy:

1. Agrees not to sue and releases and discharges Action Therapy Inc. and its employees, contractors, affiliates, managers, partners, corporations, members, agents, attorneys, staff, volunteers, aides, assistants, heirs, representatives, predecessors, successors and assigns, collectively referred to as ATI, from all liability to Participant, his personal representatives, heirs, and next of kin, for all loss or damage and waives any claim or demands an account of injury to, paralysis, or death of the Participant, or damage to the property of Participant, or economical or emotional loss arising out of the participation of Participant in the above activity, including traveling to and from an event related to this Activity. This agreement, release, waiver and discharge, shall not apply to any personal or property damage sustained by Participant arising from the negligent acts or omissions of ATI.
2. Agrees to indemnify and hold harmless ATI from any loss, liability, damage or costs that may be incurred due to the acts or omissions of Participant during participation in the above activity.
3. The undersigned certify that the Participant is physically fit and able to engage in activity at ATI.
4. In the event of any accident (or sudden illness), ATI has my permission to have performed whatever medical emergency treatment may be deemed necessary to Participant.
5. It is further agreed that the undersigned have read, understand, and agree to comply with the rules and safety provisions established for said course and/or activity.
6. Consents to the performance of services, treatments, procedures, related to physiotherapy, occupational therapy, acupuncture, acupressure, massage, Chinese herbal medicine, and other procedures within the scope of the practice of such services, by licensed personnel and any supporting staff according to state regulations.
7. *(For Acupuncture Patients)* I realize that acupuncture may be considered an investigative procedure in the United States and that there are some risks to the treatment, including but not limited to some bruising of the skin and/or slight bleeding. The risk of infection is very limited. Needles are always sterile as they either disposable or are autoclaved according to California Acupuncture Board requirements.
8. Does not expect the therapist to be able to explain or predict all risks and complications. Agrees to rely on the therapist to exercise judgment during the procedures. This consent is intended to cover the entire course of treatment for the present any future conditions.
9. Understands that as with most medical procedures, the effectiveness of treatment varies widely for each person and that results of the treatment are not guaranteed.

HIPAA – ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

We at ATI are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed and understand the above agreements, waivers, and acknowledgements and consent to their conditions.

Patient/Guardian Printed Name _____ **Signature** _____ **Date** _____

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ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items listed in the box below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need.

We expect Medicare may not pay for the items listed in the box below:

Items/Procedures	Est. Cost*	Reason Medicare May Not Pay
97001/97003 Evaluation	$90/$105	Despite your doctor's and therapist's recommendation, Medicare may decide your condition does not warrant reimbursement based on their own rules and regulations regarding medical necessity and utilization.
97002/97004 Re-evaluation	$55/$70	
97012 Mechanical Traction/Decompression	$25	
97018 Paraffin	$20	
97026 Infrared Therapy	$10	
97035 Ultra Sound	$35	
97110 Therapeutic Exercises	$35	
97112 Neuromuscular Re-education	$40	
97116 Gait Training	$35	
97124 Massage Therapy	$30	
97140 Manual Therapy	$35	
97150 Group Therapy	$25	
97530 Functional Activities	$45	
97535 Self-Care ADL/Home Management	$45	
97537 Community/Work Reintegration Training	$35	
90901 Biofeedback Training	$40	* Costs are charged per ~15 minute unit
G9283 Electrical Stimulation	$20	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the listed items in the box above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

❑ **OPTION 1.** I want the services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

❑ **OPTION 3.** I don't want the services listed above. I understand with this choice **I am not responsible for payment**, and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227 / TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

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Statement of Privacy Notice

Effective Jan 1, 2011

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.
- We may disclose your health information to your insurance provider for the purpose of payment or health care operations.
- We may disclose your health information as necessary to comply with State Workers' Compensation Laws.
- We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.
- As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
- We may disclose your health information in the course of any administrative or judicial proceeding.
- We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
- We may disclose your health information to coroners or medical examiners.
- We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.
- It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
- We may disclose your health information for military, national security, prisoner and government benefits purposes.
- We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.
- We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.
- In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.
- We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.
- We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.
- If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (800) 707-5768. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.
- Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (800) 707-5768. If our Privacy Officer Is not available, you may make an appointment for a personal conference in-person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

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Direct Physical Therapy Treatment Services

You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California.

Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

_____ _____ _____

Patient/Guardian Printed Name **Signature** **Date**

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Financial Hardship Application

The patient will need to provide documentation of proof of income and in most cases a financial disclosure form. Appropriate documentation of financial hardship would be one or more of the following:

1) **Documented proof that patient is at or below 200% of the current federal poverty guidelines (displayed below). This can include documents such as:**
   a. **W-2 withholding statements**
   b. **Pay check stubs**
   c. **Income tax return**
   d. **Forms from Medicaid or other State-funded medical assistance**
   e. **Forms from employers or welfare agencies.**

2) **Patient has other circumstances that indicate financial hardship. These can be situations such as:**
   a. **Proof of bankruptcy settlement**
   b. **Catastrophic situations (death or disability in family, divorce)**
   c. **Other documentation that shows that patient would be unable to pay medical bill and still be able to pay for other basic necessary expenses.**

Income shall be annualized from the date of request based on documentation provided and upon verbal information provided by the patient. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.

Any denial of "financial hardship" discount request will be written and will include instructions for reconsideration. If additional documentation of financial need is received to support charity care, the request will be reviewed and considered per the above guidelines. ***(All information relating to financial hardship requests will be kept confidential.)***

2011 HHS Poverty Guidelines

Persons in Family	48 States + D.C.	Alaska	Hawaii
1	$10,890	$13,600	$12,540
2	14,710	18,380	16,930
3	18,530	23,160	21,320
4	22,350	27,940	25,710
5	26,170	32,720	30,100
6	29,990	37,500	34,490
7	33,810	42,280	38,880
8	37,630	47,060	43,270
For each additional person, add	3,820	4,780	4,390

(SOURCE: *Federal Register*, Vol. 76, No. 13, January 20, 2011, pp. 3637-3638)

I hereby declare that I meet the requirements necessary to qualify for Financial Hardship and have provided the necessary documentation as proof. I understand that if I do not qualify I will be responsible for any outstanding balance. I also acknowledge that the information given herein is true and correct. I authorize Action Therapy to verify any information contained in this document for the sole purpose of assessing financial need.

Participant/Guardian Printed Name **Signature** **Date**

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Financial Disclosure Form

PATIENT NAME:			
DATE(S) OF SERVICE:			
NAME OF RESPONSIBLE PARTY:		RELATIONSHIP TO PATIENT:	
ADDRESS:		TELEPHONE:	
NUMBER OF MEMBERS IN HOUSEHOLD:			
EMPLOYER:		IF UNEMPLOYED, HOW LONG?	
EMPLOYER ADDRESS		EMPLOYER TELEPHONE	
SPOUSE'S EMPLOYER:		IF UNEMPLOYED, HOW LONG?	
EMPLOYER ADDRESS		EMPLOYER TELEPHONE	

** Attach a separate sheet for additional household members. Include their name, employer, and address.*

MONTHLY FAMILY INCOME & SOURCE	
__ Patient __ Spouse __ Responsible Party __ Children Working	
Unemployment Benefits:	
Monthly Salary (Gross):	
Public Assistance Benefits:	
Unemployment Benefits:	
Social Security Benefits:	
Workman's Compensation:	
Child Support:	
Other (Alimony, Etc.):	
TOTAL HOUSEHOLD INCOME:	

DO NOT WRITE IN THIS BOX. (FOR OFFICE PERSONNEL USE ONLY)

Document Received Date: _____

Decision: _____

Approved by: _____

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Passenger Waiver of Liability and Hold Harmless Agreement

E
In consideration for being a passenger in any vehicle that is driven by any staff or volunteer of ACTION THERAPY, I hereby **RELEASE, WAIVE, DISCHARGE AND WILL NOT SUE ACTION THERAPY**, in the State of California.

To the best of my knowledge, I fully understand being a passenger in this vehicle. I am fully aware of risks and hazards associated with this. **I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OF LOSS, OR PERSONAL INJURY, INCLUDING DEATH**, that may be sustained by me, or any loss or damage to personal property owned by me, as a result of being a passenger in this vehicle, **WHETHER CAUSED BY THE NEGLIGENCE OR ACCIDENT** or otherwise.

I further hereby **AGREE TO INDEMNIFY AND HOLD HARMLESS THE RELEASEES** from any loss, liability, damage or costs, including court costs and attorney's fees, that may incur due **WHILE BEING A PASSENGER IN SAID VEHICLE, WHETHER CAUSED BY NEGLIGENCE OR ACCIDENT** or otherwise.

It is my express intent that this Release and Hold Harmless Agreement shall bind the members of my family and spouse (if any), if I am alive, and my heirs, assigns and personal representative, if I am not alive, shall be deemed as a **RELEASE, WAIVER, DISCHARGE AND COVENANT NOT TO SUE** the above named RELEASEES. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be construed in accordance with the laws of the State of California.

I UNDERSTAND THAT THE OWNER OR OWNERS INSURANCE WILL NOT BE RESPONSIBLE FOR ANY MEDICAL COSTS ASSOCIATED WITH AN INJURY I MAY SUSTAIN WHILE BEING A PASSENGER IN SAID VEHICLE.

I also understand that I should and am urged by ACTION THERAPY to obtain adequate health and accident insurance to cover any personal injury to myself, which may be sustained during being a passenger in SAID VEHICLE or the transportation to and from SAID LOCATION AND FACILITY.

IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Waiver of Liability and Hold Harmless Agreement, understand it and sign it voluntarily as my own free act and deed; no oral representations, statements or inducements, apart from the foregoing written agreement, have been made; I am at least eighteen (18) years of age and fully competent; and I execute this Release for full, adequate and complete consideration fully intending to be bound by same.

IN WITNESS WHEREOF, I have hereunto set my hand on this below signed date.

Patient/Guardian Printed Name	**Signature**	**Date**

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Action Therapy Patient Intake Questionnaire

Personal History:

Name: _____ Date: _____

Phone: _____ DOB: _____

Gender (circle): Male / Female

Medical History:

Do you exercise regularly? ☐ Yes / ☐ No

Do you smoke? ☐ Yes / ☐ No

If yes, how much and how often: ____ (packs/day)

Do you have a pacemaker? ☐ Yes / ☐ No

What medications are you currently taking? _____

Surgical History (in the last 10 years): _____

Do you currently have any of the following conditions? (Check all that apply):

☐ HIV/AIDS	☐ Anemia	☐ Arthritis (Rheumatoid? ☐ Yes / ☐ No)	
☐ Asthma	☐ Blood clots	☐ Cancer	☐ Depression
☐ Diabetes	☐ Dizziness	☐ Epilepsy	☐ Heart Problems
☐ High Blood Pressure	☐ High Cholesterol	☐ Liver problems	☐ Lung Disease
☐ Parkinsons Disease	☐ Poor Circulation	☐ Stroke	☐ Bowel/Bladder Problem

Reason for Therapy:

What is your current need for therapy? _____

Primary area of pain (check **one**):

☐ Neck ☐ Low back ☐ Arms, Shoulders, Hands, Wrists ☐ Lower Extremities

When did this begin? _____

Cause? _____

What makes your pain worse? _____

Better? _____

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When during the day is your pain at its worst? (Check one)

☐ Morning ☐ Afternoon ☐ Evening ☐ All day

How long does your pain last? (Check one)

☐ Only with Certain Motions ☐ Intermittently ☐ Constantly

Please rate your pain from 0 – 10: At Worst? _____ Currently? _____ At Best? _____

Does your current problem affect your ability to participate in daily activities? Y / N

Do you currently have difficulty with any of these activities? (Check all that apply):

☐ Bathing/showering ☐ Cooking ☐ Cleaning home
☐ Toileting ☐ Driving ☐ Gardening
☐ Getting Dressed ☐ Public Transportation ☐ Social Participation
☐ Grooming/Hygeine ☐ Taking Medication ☐ Rest/Sleep
☐ Self-feeding ☐ Manage Finances ☐ Fitness Activities: _____
☐ Leisure Activities ☐ Work/Volunteer ☐ Caring for Others: (who) _____
☐ Other: _____

What daily tasks are most important to you?

_____

_____

What preferred activities can you no longer do because of your diagnosis/problem?

_____

What roles do you want or need to do on a daily basis?

_____

Do you require assistance with self-care tasks? ☐ Yes / ☐ No

Have you fallen in the last 6 months? ☐ Yes / ☐ No

How many times? _____

Have you fallen in the last 2 weeks? ☐ Yes / ☐ No

How many times? _____