



Patient Information Form

Last Name First Name Middle
Address City/State Zip
Home Phone Cell Phone Work Phone
Date of Birth SSN Email Address
Employer Marital Status Facebook

Spouse's Name Work Phone # DOB
Nearest Friend/Relative not living with you: Phone #
Emergency Contact Name Phone#

Physician Phone #
Whom may we thank for referring you to us?
IF self-referral-how did you hear about us?

Insurance Company Secondary Ins. Co.
Policy # Policy #
Group # Policy #

Workman' Comp Claim? Yes No If Yes, date of injury
Insurance Co. Adjuster Name Claim #
Phone # Fax # Adjuster Name DOI

Auto Accident? Yes No
Have you been seen for PT/OT or Chiropractor during the calendar year? Yes No
Why did you choose Fast Track Therapy for your therapy services?

Who is the responsible party? / Legal guardian if a minor?
Date of Birth Phone # SSN
Address Will you be paying today by: Cash Check CC

Please provide proof of insurance coverage upon completion of this form.
Assignment and Authorization: I authorize the release of any medial information necessary to process insurance/Medicare claims on my behalf. I authorize payment of medical benefits directly to Fast Track Physical Therapy for services and supplies provided to me. A copy of this authorization shall be considered as valid as the original and valid for the duration of my care. I understand I am eligible for all charges incurred should my insurance not pay for these services (Except for Workers' Comp.)

Signature Date

Patient Experience?
How was your experience when scheduling and first point of contact with our staff?
How long did it take you to get in? Less than 48 hrs. More than 48 hrs. More than 72 hrs. If more than 72 hrs., was that by your request? Yes No Do you know who you talked to? Were you greeted upon arrival? Yes No Was the staff member friendly and did they answer all your questions? Yes No Please rate your initial experience with us. Exceeded my expectations Very Satisfied Satisfied Not Satisfied

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Referring Dr.: \_\_\_\_\_ Next Follow up Apt? \_\_\_\_\_

What is your main complaint or problem? \_\_\_\_\_

Date of onset: \_\_\_\_\_ How did it occur \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight \_\_\_\_\_

Do you have a history of falls or have fallen in the past year? Yes \_\_\_ No \_\_\_ If yes did it result in injury? Yes \_\_\_ No \_\_\_

Frequency of Symptoms: Constant \_\_\_ Frequent \_\_\_ Occasional \_\_\_ Intermittent \_\_\_

Pain level in the past 24 hours: No pain- 0 1 2 3 4 5 6 7 8 9 10- Extreme pain

Pain level in the past week: No pain- 0 1 2 3 4 5 6 7 8 9 10- Extreme pain

Pain at its best and worse: No pain- 0 1 2 3 4 5 6 7 8 9 10- Extreme pain

If you have pain, please circle those words which best describe it. *Decreased/Loss of function Loss of balance Sharp Dull Burning Throbbing Twinge Ache Numb Tingle Tight Pulling Weakness Stiffness*

What medications are you taking for this problem? Please list the names of the medications: \_\_\_\_\_  
*Anti-inflammatory Pain killer Muscle relaxer Other*

List of other medications you are currently taking: \_\_\_\_\_

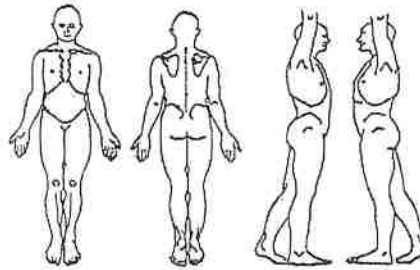
Date of surgery (if applicable) \_\_\_\_\_ Type of surgery \_\_\_\_\_

Please indicate painful areas by shading models.

X = pain

/ = tingling

O = numbness



How do you feel in the Morning? *Better/worse* Afternoon? *Better/worse* Evening? *Better/worse* Night? *Better/worse*

What positions or activities make your pain better? \_\_\_\_\_

What positions or activities make your pain worse? \_\_\_\_\_

What tests/or treatment have you had for this problem? What were the findings? Previous Therapy?

*X-ray MRI CT Scan Myelogram EMG Other*

What is your occupation? \_\_\_\_\_ Working: *Full time Light duty Not working*

Physical work requirements: *sedentary light moderate heavy very heavy*

Job requires prolonged: *sitting standing bending walking lifting squatting driving*

Do you have any of the following: *severe or frequent headaches dizziness bowel or bladder problems diabetes fibromyalgia stroke high blood pressure pacemaker Parkinson's pregnant*

What are your goals you wish to accomplish with physical therapy? \_\_\_\_\_



## Welcome to Our Office

We are pleased that you have chosen FastTrack Physical Therapy for your outpatient physical therapy- This information answers some of the most commonly asked questions about our services. Feel free to ask any additional questions. We look forward to working with you to attain your goals.

Payment for services: As a courtesy to you, we will obtain authorization and bill your insurance company. Please note: All insurance co-pays and co-ins are expected at the time services are rendered. It is the patient's responsibility to know their insurance plan and coverage.

Regarding Appointment: Appointment times range from 60-90 minutes. Our facility remains very busy, especially the early morning and late afternoon appointments. It is important for you to attend your appointments regularly. Inconsistency in receiving your therapy treatments can adversely affect your progress and outcome. If you need to cancel your appointment, please call 24 hours prior to your appointment to allow us to provide services to other patients. There will be a **\$35 cancelation fee** for no shows or cancelations without 24-hour notice. Patients that consistently cancel or no-show appointments will be discharged and their doctor will be notified of the reason of discharged. Punctuality is appreciated so you can receive the maximum benefit from your appointment. Our staff does their best to be on time.

Works Compensation Patients Only: Please note that this office will notify your Workman's Compensation Insurance Adjuster of non-compliance after missed appointments.

Reposts to Physicians: We send a summary of your initial visit to your doctor. Please let us know 5-7 days in advance of future doctor appointments so we can send a letter informing them of your progress. Your written consent will be required to release medical records to anyone other than your physician and insurance company.

Hours of Operation: 7:00 am-7:00 pm Monday-Friday

Team Approach: Occasionally you may see a different Physical Therapist or Physical Therapist Assistant. This can offer new perspectives in treating your condition and enhance your progress. Your program and the services provided may change in response to your progress and needs. It is important that you do your home exercise program to improve your rate of progress. We look forward to working with you.

I will allow Fast Track Physical Therapy to use my testimonials. Yes \_\_\_ No \_\_\_

I will allow Fast Track Physical Therapy to use my photos for publication. Yes \_\_\_ No \_\_\_

**I have received a copy of the Outpatient Guidelines and Privacy Practice HIPPA form, and I consent to treatment by the Fast Track Therapy staff.**

Signature: \_\_\_\_\_ Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_