Health Risk Questionnaire

Name _____ Age _____ Weight _____ Height _____

Please explain "Yes" answers in the spaces provided.	Yes	No
Do you have heart trouble?_____	___	___
Do you have high blood pressure?_____	___	___
Has a member of your family had a heart trouble/stroke before age 60?_____	___	___
Do you have diabetes?_____	___	___
Do you smoke/chew tobacco?_____	___	___
Do you have asthma, bronchitis, emphysema?_____	___	___
Have you had rheumatic fever or tuberculosis?_____	___	___
Do you experience sudden, unexplained shortness of breath?_____	___	___
Do you experience sudden, unexplained rapid heartbeats?_____	___	___
Do you a disabling bone or joint disease (ex. Arthritis)?_____	___	___
Are you taking any medication (please list)?_____	___	___
_____		
Have you recovered from any acute illness or viral infection?_____	___	___
Has a medical doctor informed you to not participate in exercise?_____	___	___
Have you had an operation of any kind?_____	___	___
Have you recently had a checkup from your doctor?_____	___	___
Is there any other health information we should know that may affect your treatment?_____	___	____
Females: are you pregnant? (Please circle) YES NO		
Other than my reason for being here today, I am in good health	____	___

I understand that if my medical condition, allergies or medication change, I need to inform the CPT staff. Medications particularly, may influence the way you feel.

Signature:_____

Print:_____ Date:_____

301 RHL Blvd. Ste 202 Charleston, WV 25309 Ph: (304) 746-9200 Fax: (304) 746-9202 www.cptwv.com

Welcome to Charleston Physical Therapy

New Patient Registration Date_____

Name _____
LAST FIRST MI

Address _____
CITY STATE ZIP

Personal Info _____
M/F DOB SSN MARITAL STATUS

Contact Info _____
HOME # CELL# EMAIL (for follow-up purposes)

Employer _____Occupation _____ Work# _____

Emergency Contact _____
NAME & RELATIONSHIP (not in same home) PHONE

Name of person we can release information to and their relationship to patient:

(Billing, Appointments, Records) _____
NAME RELATIONSHIP PHONE

Who Referred You to CPT? Friend/Family_____ Physician_____

Area of Injury _____Injury Date_____

This year: Have you had home health?_____ Or therapy in another clinic?_____

Physician Name _____ Have You Seen Them for this Injury_____

Who is to be Billed: (mark with X) Private Insurance _____ Self ___

Work Comp ___ Claim#_____ Auto/Accident Insurance _____ Claim#_____

Insurance Company Name _____ Member ID _____

Primary Card Holder _____
NAME SSN DOB

Relationship to Patient: (please circle) SELF SPOUSE PARENT OTHER_____

Secondary Insurance Name _____ Member ID _____

Secondary Card Holder _____
NAME SSN DOB

Relationship to Patient: (please circle) SELF SPOUSE PARENT OTHER_____

CONSENT FOR TREATMENT
GUARANTEE OF ACCOUNT AND ASSIGNMENT OF INSURANCE BENEFITS

CONSENT is hereby given to Charleston Physical Therapy Specialists (CPT) and the Physical Therapists, Occupational Therapists and Physical Therapy Assistants taking care of me to administer such therapeutic procedures that are deemed necessary on an outpatient physical therapy basis. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the result of evaluation and treatment either in the clinic or as a result of my home practice. I understand that there is a risk involved with any physical therapy or therapeutic program, such as: increased soreness, fractures, heart attack pain and death.

_____
INITIAL

FURTHERMORE, I accept responsibility for payment of all charges and fees for all outpatient treatment services provided. I further authorize that any insurance benefits that are reimbursable for such service be paid directly to CPT and consent to the release of any medical information that may be required to verify the justness of any claim made as a result of this outpatient therapy and payment thereof. I understand that CPT will bill my insurance carrier on my behalf for all charges incurred; however, I agree that I am responsible for the full amount of my account (with the exception of certain government insurance plans).

_____
DATE SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

1. I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to or obtain from the Social Security Administrator or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physical therapist or organization furnishing the services or authorize such physical therapist or organization to submit a claim to Medicare for payment to me.

_____
INITIAL

1. Acknowledgment of receipt of statement of my rights while I am a Medicare patient.

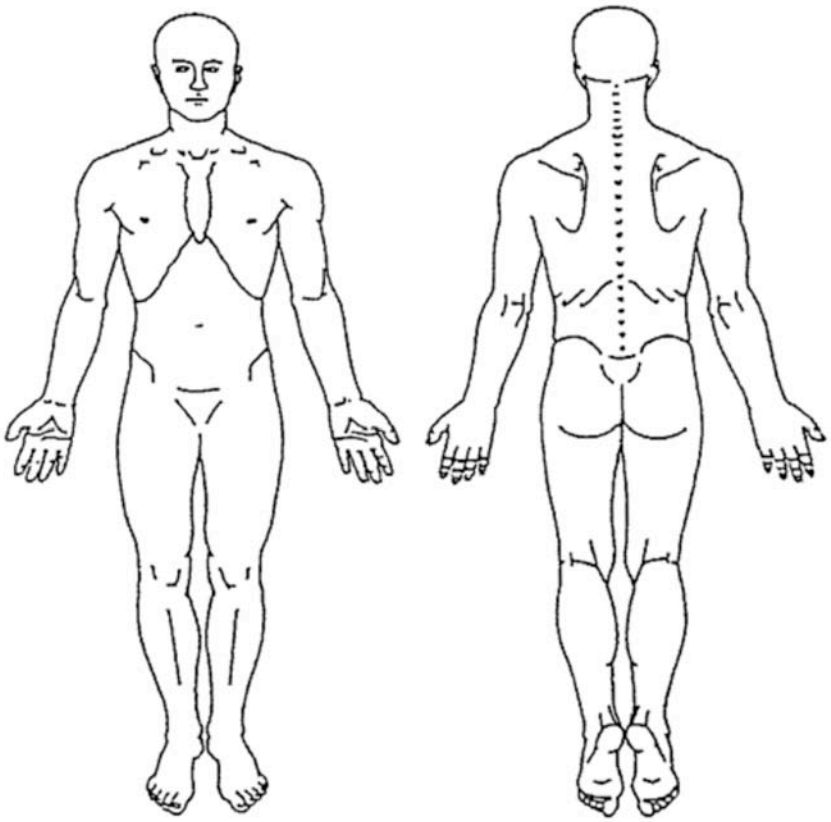
_____
INITIAL

1. This is to acknowledge that I received a copy of CPT's Notice of Privacy Practices as required by HIPPA.

_____
INITIAL

Name _____ DOB _____/_____/_____

On the body diagram below, shade in the area(s) where you are having pain, tingling or numbness with this episode.



On the 0 - 10 scale provided below, circle the average pain level for this episode.

0 1 2 3 4 5 6 7 8 9 10

Best Worst

On the 0% - 100% scale provided below, circle the percent of normal function at which you are currently able to preform. This includes; work performance, activities at home, sports and socially with friends.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Worst Best

Current Medications_____

_____

_____

_____