MEGAMOTION
PHYSICAL THERAPY

NEW PATIENT INSURANCE INFORMATION

PATIENT NAME:
DATE OF BIRTH:

CONTACT NUMBER:

HOME:
MOBILE:
WORK:

INSURANCE CARRIER:

PRIMARY INSURANCE:	ID/CLAIM NUMBER:
SECONDARY INSURANCE:	ID/CLAIM NUMBER:

DIAGNOSIS:

REASON FOR PHYSICAL THERAPY:	ICD CODES:

EVALUATION NOTES (TO BE FILLED OUT BY PHYSICAL THERAPIST)

What are your goals for physical therapy?

_____

_____

One activity you would love to do that you cannot do now?

_____

Any of the following that are NEW, UNUSUAL or ATYPICAL for you?

☐ **Yes** ☐ **No** Weight loss/gain	☐ **Yes** ☐ **No** Dizziness/Light headedness
☐ **Yes** ☐ **No** Fatigue	☐ **Yes** ☐ **No** Urinary incontinence
☐ **Yes** ☐ **No** Numbness/Tingling	☐ **Yes** ☐ **No** Joint/Muscle swelling
☐ **Yes** ☐ **No** Double/Loss of vision	☐ **Yes** ☐ **No** Difficulty breathing
☐ **Yes** ☐ **No** Regular cough	☐ **Yes** ☐ **No** Pregnant or might be pregnant
☐ **Yes** ☐ **No** Difficulty swallowing	☐ **Yes** ☐ **No** Hearing problems
☐ **Yes** ☐ **No** Problems urinating	☐ **Yes** ☐ **No** Night sweats
☐ **Yes** ☐ **No** Weakness	☐ **Yes** ☐ **No** Problem sleeping

MEGAMOTION
PHYSICAL THERAPY

NEW PATIENT WORKERS' COMP INSURANCE INFORMATION

PATIENT NAME:
DATE OF BIRTH:

CONTACT NUMBER:

HOME:	MOBILE:

WORKERS' COMP INFORMATIONS:

INSURANCE:	
CLAIM/CARRIER CASE NUMBER:	WCB CASE NUMBER:
DATE OF ACCIDENT/INJURY:	SOCIAL SECURITY NUMBER:
CLAIMING ADDRESS:	
CLAIM ADJUSTER:	
ADJUSTER'S CONTACT NO:	ADJUSTER'S FAX NO:

EMPLOYER'S INFORMATIONS:

NAME:	CONTACT NUMBER:
ADDRESS:	

DIAGNOSIS:

REASON FOR PHYSICAL THERAPY:	ICD CODES:

EVALUATION NOTES (TO BE FILLED OUT BY PHYSICAL THERAPIST)

What are your goals for physical therapy?

_____

_____

One activity you would love to do that you cannot do now?

_____

Any of the following that are NEW, UNUSUAL or ATYPICAL for you?

☐ **Yes** ☐ **No** Weight loss/gain	☐ **Yes** ☐ **No** Dizziness/Light headedness
☐ **Yes** ☐ **No** Fatigue	☐ **Yes** ☐ **No** Urinary incontinence
☐ **Yes** ☐ **No** Numbness/Tingling	☐ **Yes** ☐ **No** Joint/Muscle swelling
☐ **Yes** ☐ **No** Double/Loss of vision	☐ **Yes** ☐ **No** Difficulty breathing
☐ **Yes** ☐ **No** Regular cough	☐ **Yes** ☐ **No** Pregnant or might be pregnant
☐ **Yes** ☐ **No** Difficulty swallowing	☐ **Yes** ☐ **No** Hearing problems
☐ **Yes** ☐ **No** Problems urinating	☐ **Yes** ☐ **No** Night sweats
☐ **Yes** ☐ **No** Weakness	☐ **Yes** ☐ **No** Problem sleeping

MEGAMOTION
PHYSICAL THERAPY

NEW PATIENT NO FAULT INSURANCE INFORMATION

PATIENT NAME:
DATE OF BIRTH:

CONTACT NUMBER:

HOME:
MOBILE:
WORK:

INSURANCE CARRIER:

PRIMARY INSURANCE:	
ID/CLAIM NUMBER:	DATE OF INJURY/ACCIDENT:
CLAIMING ADDRESS:	
CLAIM ADJUSTER:	
ADJUSTER CONTACT NO:	ADJUSTER FAX NO:

DIAGNOSIS:

REASON FOR PHYSICAL THERAPY:	ICD CODES:

EVALUATION NOTES (TO BE FILLED OUT BY PHYSICAL THERAPIST)

What are your goals for physical therapy?

_____

_____

One activity you would love to do that you cannot do now?

_____

Any of the following that are NEW, UNUSUAL or ATYPICAL for you?

☐ **Yes** ☐ **No** Weight loss/gain	☐ **Yes** ☐ **No** Dizziness/Light headedness
☐ **Yes** ☐ **No** Fatigue	☐ **Yes** ☐ **No** Urinary incontinence
☐ **Yes** ☐ **No** Numbness/Tingling	☐ **Yes** ☐ **No** Joint/Muscle swelling
☐ **Yes** ☐ **No** Double/Loss of vision	☐ **Yes** ☐ **No** Difficulty breathing
☐ **Yes** ☐ **No** Regular cough	☐ **Yes** ☐ **No** Pregnant or might be pregnant
☐ **Yes** ☐ **No** Difficulty swallowing	☐ **Yes** ☐ **No** Hearing problems
☐ **Yes** ☐ **No** Problems urinating	☐ **Yes** ☐ **No** Night sweats
☐ **Yes** ☐ **No** Weakness	☐ **Yes** ☐ **No** Problem sleeping

MEGAMOTION
PHYSICAL THERAPY

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire in its entirely. This confidential medical history will be part of your permanent records. Provide as much detail as possible to provide your therapist with a comprehensive overview of your case and present condition. Thank you!

Patient's Full Name: _____ **Nickname:** _____ **Date of Birth** (MM/DD/YYYY)**:** _____

How did you hear about Megamotion Physical Therapy?

☐ Workplace ☐ Email ☐ Physician ☐ Workers' Comp ☐ Website ☐ Facebook ☐ Friend/Family _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Ext.** _____

Email: _____ **May we leave a voice message? ☐ Yes ☐ No**

Social Security Number: _____ **Marital Status: ☐ S ☐ M ☐ W ☐ D Sex: ☐ M ☐ F**

Occupation: _____ **Employer:** _____

Emergency Contact Person / Relation: _____ / _____ **Phone No.** _____

Please list anyone in which we have permission to speak to regarding treatment or scheduling: _____

INSURANCE

Primary Insurance: _____ **ID/Claim Number:** _____

Secondary Insurance: _____ **ID/Claim Number:** _____

Insured's Name: _____ **Insured's Date of Birth** (MM/DD/YYYY)**:** _____

Phone Number: _____ **Insured's Sex: ☐ M ☐ F**

Patient relationship to Insured: ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Child ☐ Other _____

MEDICAL HISTORY

Describe in detail, what is your major complaint/ restriction(s)?

_____

_____

Have you been treated for this condition before? ☐ Yes ☐ No

If yes, when did your latest symptoms appear? _____

What caused/preceded this condition? _____

Is this condition: ☐ Job related ☐ Auto Accident ☐ Other: _____

Date of Accident (MM/DD/YYYY)**:** _____ **Date of Onset** (MM/DD/YYYY)**:** _____

Is this condition interfering with: ☐ Work/School ☐ Sleep ☐ Daily routine ☐ Other _____

Is this condition: ☐ Improving ☐ Unchanging ☐ Getting worst ☐ Intermittent

Prior to this injury/problem did you have limitations with your daily activities? ☐ Yes ☐ No If yes, please explain:

Do you have a primary doctor? ☐ Yes ☐ No If Yes, Name: _____

REQUIRED BY INSURANCE:

Medication					
Dose					
Frequency					

Please check if you have taken any of the following medications in the last week:

	Physician prescribed?		Physician prescribed?
☐ Aspirin	☐ Yes ☐ No	☐ Herbals	☐ Yes ☐ No
☐ Stomach ulcer meds	☐ Yes ☐ No	☐ Tylenol	☐ Yes ☐ No
☐ Vitamin/Mineral/Dietary Supplements	☐ Yes ☐ No	☐ Anti-inflammatories (Motrin/Advil/Ibuprofen etc.)	☐ Yes ☐ No

Have you fallen down or lost your balance enough to stumble to grab on something in the last year? ☐ Yes ☐ No

If yes, when, where and how? _____

Are you receiving or have you recently received other therapy services for this condition? ☐ Yes ☐ No

How much caffeinated coffee or beverage containing caffeine do you drink per day? _____
Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____ If quit, when? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how many days per week? _____
If one drink equals one beer or glass of wine, how much do you drink on an average sitting? _____
Have you previously been in auto accident or had any personal injury? ☐ Yes ☐ No
If Yes, please list the injuries you sustained in the past and the approximate date of injury:

SELF HISTORY

Have you ever been diagnosed with any of the following conditions?

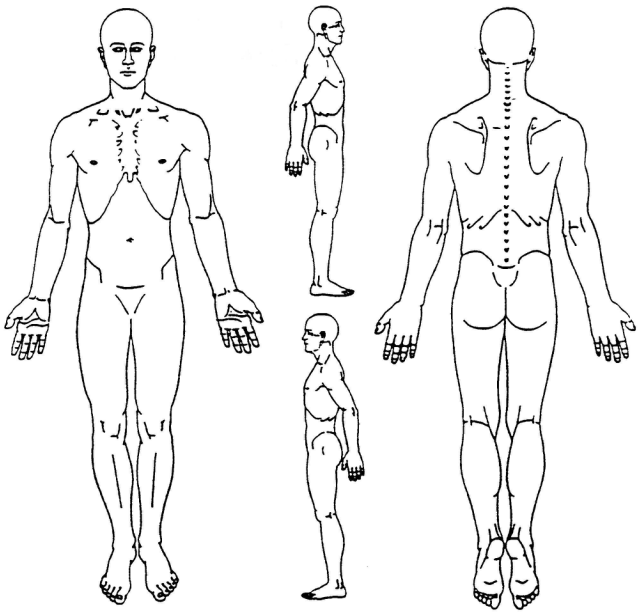
☐ Yes ☐ No Cancer. If yes. What kind? _____
☐ Yes ☐ No Diabetes. Type I / II
☐ Yes ☐ No Kidney problems
☐ Yes ☐ No High blood pressure. Controlled? Y / N
☐ Yes ☐ No Stroke/Heart attack. Date: _____
☐ Yes ☐ No Heart problems _____
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Rheumatoid Arthritis
☐ Yes ☐ No Asthma
☐ Yes ☐ No Thyroid problems
☐ Yes ☐ No Depression/Mental Illness
☐ Yes ☐ No Drug/Alcohol Abuse
☐ Yes ☐ No Severe Allergies. To: _____
☐ Yes ☐ No Stomach ulcer
☐ Yes ☐ No Blood clots. When/Where? _____
☐ Yes ☐ No Hepatitis

Please clarify any above checks:
_____

ADDITIONAL MEDICAL HISTORY

Hospitalization surgeries/dates:

X-rays/MRI: ☐ Yes ☐ No Results (if known): _____
Current Weight_____ (lbs.) Current Height _____ (ft/inches)



PAIN OR SYMPTOM INTENSITY
Please mark your symptoms on the figure accordingly:
REQUIRED BY INSURANCE:
Rate the intensity of your pain or symptoms from 0 to 10 with "0" denoting none and "10" denoting most severe/intense.

How bad are your symptoms now? ____ / 10

How bad have they been in the past week? ____ / 10

What is the least pain in the past week? ____ / 10

Type of pain:

☐ Burning ☐ Sharp
☐ Dull/Achy ☐ Throbbing
☐ Shooting ☐ Numbness/Tingling
☐ Constant ☐ Intermittent
☐ Worst in AM ☐ Worst in PM
☐ Worst at Night ☐ Other _____

Most painful activity? _____

Therapist Signature: _____ Date: _____
(By signing, therapist acknowledges reviewing medical history)

PATIENT SIGNATURE: _____ Date: _____
(Parent/Guardian if younger than 18 years old)

MEGAMOTION PHYSICAL THERAPY

OUTPATIENT PHYSICAL THERAPY CONSENT

NAME: _____ DATE OF BIRTH: _____

CONSENT TO RECEIVE SERVICES	I hereby authorize Megamotion Physical Therapy to render appropriate outpatient services to the named above. I recognize and agree that I have the right to refuse treatment or terminate services at any time.
AUTHORIZATION FOR EMERGENCY MEDICAL SEVICES	At any time while receiving services from Megamotion Physical Therapy and in the event of any medical emergency, I authorize Megamotion Physical Therapy or its employees/contractors to provide or obtain such medical treatment as they deem advisable under the circumstances, and I agree to assume sole responsibility for all charges for such treatment.
RELEASE OF MEDICAL RECORDS	I hereby consent and request that copies of my therapy treatment records be provided to the following for the period of my current start of care date to discharge date: (Physician) _____ (Physician other) _____ (Family member) _____
MEDICARE AUTHORIZATION	If a Medicare patient, I certify that the information given to me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I request that payment of authorized benefits be made to Megamotion Physical Therapy on my behalf.
NOTICE OF PRIVACY PRACTICES	I acknowledge that I have read copy of the Megamotion Physical Therapy Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Megamotion Physical Therapy and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.
FINANCIAL RESPONSIBILITY	**I understand that I am financially responsible to Megamotion Physical Therapy for all charges whether or not paid by my insurance. I also understand that I will be responsible for any copay or deductible as defined by my insurer. I also understand that my remaining account balance will become due upon completion of care according to terms of repayment.** I hereby authorize the release of any medical or other information necessary to process my medical claims and to obtain payment of benefits. I authorized my insurance company, attorney or 3rd party payer to assign all payment benefits directly to Megamotion Physical Therapy for the services rendered. I will also pay any charges incurred for bounced checks, collection, and court and attorney fees.
MISSED VISIT POLICY	**In an instance of a cancellation or no-show without 24 hours' notice, we reserve the right to charge you a $30 cancellation/no-show fee. This fee will not be covered by any insurance. Additionally, tardiness of 20 minutes may result in rescheduling of the appointment for another time.**
	I have read and agree to the above statements and certify that the above information given is correct to the best of my knowledge. Patient Signature _____ Date: _____ Parent/Guardian Signature _____ Date: _____

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