Professional Rehabilitation Associates, PSC
d/b/a Paris Physical Therapy
2117 Riverside Drive
Paris, KY 40361
859 988-5005

Reset Form

New Patient Information

Last Name: _____ Date of Birth: _____

First Name: _____ Middle Initial: ____ Home Phone: _____

Street: _____ Social Security #: _____

City: _____ State: _____ Zip: _____ Sex: ☐ Male ☐ Female

Employer: _____ Work Phone: _____

Street: _____ Occupation: _____

City: _____ State: _____ Zip: _____ Supervisor: _____

Responsible Party/Card Holder Information

Last Name: _____ Relationship to Patient: _____

First Name: _____ Daytime Phone: _____

Street: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____ SSN: _____

Emergency Contact Information

Full Name: _____ Daytime Phone: _____

Relationship to Patient: _____ Work Phone: _____

Have you seen a Physical, Occupational or Speech Therapist this year? ☐ No ☐ Yes Describe: _____

Have you had Home Health this year? ☐ No ☐ Yes Describe: _____

Is this injury related to: Automobile Accident: ☐ Worker's Compensation: ☐ Other: _____

Date of Injury/Onset: _____ Did you report the injury? ☐ No ☐ Yes Date Reported: _____

Describe Injury: _____

_____

How did you hear about us? ☐ Physician Referral ☐ Newspaper ☐ Phone Book ☐ Family/Friend Other: _____

Your referral to this facility may have been as a result of our ongoing marketing efforts to current or potential referral sources.

I hereby authorize payment of medical benefits to Professional Associates, PSC for services rendered. I further authorize the release of medical information required to process an insurance claim on my behalf. I certify a copy of the authorization to be a valid original. All costs of services not paid for by my insurance will become my responsibility.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Evaluating Therapist Name: _____

Print Form

PROFESSIONAL REHABILITATION ASSOCIATES, PSC
d/b/a Paris Physical Therapy Associates

Acknowledgment of Receipt of Notice of Privacy Practices

This is to acknowledge my receipt of PRA's Notice of Privacy Practices on the date stated below.

Date of Patient's or Personal Representative's Signature

Signature of Patient or Personal Representative

Patient's Name

Patient's Address

Name of Personal Representative
(If applicable)

Description of Representative's Authority to Act for the Patient (If Applicable)

Professional Rehabilitation Associates, PSC
d/b/a Paris Physical Therapy
2117 Rocky Drive
Paris, KY 40361
(859) 988-5005 phone
(859) 988-5006 fax

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS AND REPORTS

I, the undersigned, hereby authorize _____ to release the following information of the health record(s) of the below named patient:

Patient Name	Patient Address	Date of Birth	Phone

Information to be released:

( ) Entire Record ( ) Op Report ( ) Lab Report
( ) Discharge Summary ( ) Path Report ( ) Outpatient
( ) H&P ( ) X-ray Report
( ) Other (specify): _____

Date(s) of Service: _____

Information to be released to:

Name of Person or Institution Address

For the following purpose: _____

I understand that I have the right to revoke this authorization at any time except to the extent Richmond Physical Therapy has already acted as a result of this authorization. I further understand that any revocation must be provided in writing to Richmond Physical Therapy as identified in the Notice of Privacy Practices.

I also understand that when information is used or disclosed based on an authorization; the information may be re-disclosed by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information.

This authorization shall expire within _____ days from the date of this authorization.

I understand that I have the right to refuse to sign this authorization and that Richmond Physical Therapy will not condition treatment on the provisions of this authorization.

Signature of Patient or Legal Representative Date

If signed by the Patients Legal Representative, please provide a description of Legal Representative's authority to act on behalf of the Patient.

Authorization & Consent For Treatment

Physical, Occupational and Speech Therapies are patient care services provided in response to a wide variety of medical care needs for patients of all ages, regardless of gender, color, race, creed, national origin or disability.

The purpose of these therapies are to treat disease, injury and disability by evaluation, examination, testing and use of rehabilitative procedures, manipulation, mobilization, exercises, education, and physical agents including mechanical devices, heat, cold, air, light, water, electricity and sound in the aid of diagnosis or treatment. Other purposes of these therapies are to obtain for the physician, information needed for diagnosing and evaluation of patients, to prevent or minimize physical and mental disability, to aid the patient in achieving maximum potential within their capabilities, and to accelerate convalescence and to reduce the length of functional recovery.

The above professional practices include the use of therapeutic exercises, ultrasound, electrical stimulation, work conditioning, swallowing training, electromyographic testing, nerve conduction testing, thermography, transcutaneous electrical nerve stimulation, traction, application of topical medications, sharp debridement, bracing, casting, splinting, phonophoresis, iontophoresis, and biofeedback.

All procedures will be thoroughly explained to you before you are asked to perform or receive them.

Depending on your current condition, you may or may not experience an increase in your current level of pain or discomfort. If you experience an increase in pain or discomfort, it will be your responsibility to notify your caregiver immediately. This will enable your therapist to make necessary adjustments to your plan of care.

There are certain inherent risks with therapeutic treatment. You will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. This risk is small and you will be able to control any procedure by stopping if you feel an increase in pain or discomfort in any other part of your body. The therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

Based on the above information, I agree to cooperate fully and to participate in all therapy procedures and to comply with the plan of care as it is established. I acknowledge that I have read this authorization and compliance for treatment.

Patient Signature:_____ Date: _____

Witness Signature: _____ Date: _____

Professional Rehabilitation Associates, PSC
Physical Therapy New Patient Information

Name: _____ Date: _____ Birthdate: _____ Age: ____

Referring physician: _____ Height: _____ Weight: _____

CURRENT CONDITION(S) / CHIEF COMPLAINT(S)

1. Describe the problem(s) / symptom(s) for which you seek physical therapy:

   _____

   _____

2. When did the problem(s) / symptom(s) begin (date/estimate if necessary)? _____

3. What happened? _____

   _____

4. If you are here following surgery, what was the date of your surgery? _____

   a. Have you ever had the problem(s) before?
      I. Yes ____
         1. What did you do for the problem(s)? _____
         2. Did the problem(s) get better? Yes____ No____
         3. About how long did the problem(s) last? _____
      II. No ____

5. How are you taking care of the problem(s) now? Ice, medications, etc...? _____

   _____

6. What makes the problem(s) better? _____

7. What makes the problem(s) worse? _____

8. Are you seeing anyone else for the problem(s) / symptom(s) (Check all that apply)

Chiropractor	____	Family physician	____	Orthopedist	____
Neurologist	____	Neurosurgeon	____	Pain management	____
Dentist	____	Rheumatologist	____	Other: _____	

MEDICAL/SURGICAL HISTORY

1. Please circle, if you have ever had:

Arthritis	Broken bones	Osteoporosis	Thyroid problems
Blood disorders	Circulation problems	Heart problems	High blood pressure
Lung problems	Stroke/TIA	Cancer	Muscular dystrophy
Diabetes	Low blood sugar	Head injury	Hepatitis
Multiple sclerosis	Tuberculosis	Kidney problems	Repeated infections
Ulcers/stomach problems	Skin diseases	Depression	Blindness/glaucoma
Chronic fatigue	Deafness	Epilepsy/seizure	Back & or neck pain
Pacemaker	Other: _____		

2. Within the past year, have you had any of the following symptoms? (Circle all that apply)

Chest pain	Hoarseness	Cough	Heart palpitations
Shortness of breath	Dizziness/blackouts	Loss of balance	Coordination problems
Difficulty walking	Joint pain or swelling	Pain at night	Weakness in arms or legs
Difficulty sleeping	Loss of appetite	Nausea/vomiting	Difficulty swallowing
Bowel problems	Weight loss/gain	Urinary problems	Fever/sweats/chills
Headaches	Hearing problems	Vision problems	Other: _____

3. Have you ever had surgery? Yes____ No ____ If yes, please describe and include dates or years:

   _____

Professional Rehabilitation Associates, PSC

4. **For men only:** Have you been diagnosed with prostate disease? Yes____ No ____

5. **For women only:** Are you or do you think you might be pregnant? Yes ____ No____

OTHER CLINICAL TESTS: Within the past year, have you had any of the following tests? (Circle all that apply)

MRI	CT scan	X-rays	NCV/EMG
Arthroscopy	Biopsy	Blood tests	Bone scan
Doppler ultrasound	Echocardiogram	EEG	EKG
Mammogram	Stress test	Myelogram	Other:_____

MEDICATIONS

1. Do you take prescription medications? Yes ____ No____

   If yes, please list: _____

   _____

2. Do you take any nonprescription medications? (Circle all that apply)

Advil/Aleve	Antacids	Ibuprofen/Naproxen	Antihistamines
Aspirin	Decongestants	Herbal supplements	Tylenol
Other:_____			

FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that apply)

____Difficulty with getting in and out of bed
____Difficulty walking on level ground
____Difficulty walking on uneven terrain
____Difficulty with self-care (bathing, dressing, etc..)
____Difficulty with home management (household chores, shopping, driving, caring for dependents)
____Difficulty transferring (bed to chair, bed to commode, etc.)
____Difficulty climbing stairs
____Difficulty with work/school activities
____Difficulty with recreation or play activities

SOCIAL HISTORY/LIVING ENVIRONMENT

With whom do you live?
____Alone ____Spouse alone ____Spouse & others____Personal care attendant
____Other relatives ____Child Other: _____

Where do you live?
____Private home ____Assisted living ____Long-term care facility Other:_____

Does your home have:
____Stairs no railing ____Stairs, railing ____Ramps ____Uneven terrain
____Any obstacles? Describe:_____

Do you use:
____Cane ____Walker ____Manual wheelchair ____Motorized wheelchair

Employment/work (job/school/play)
____Working full-time outside of home
____Working full-time from home
____Homemaker
____Unemployed
____Working part-time outside home
____Working part-time from home
____Retired
____Student

Occupation: _____

General Health Status
Please rate your health: ____Excellent ____Good ____Fair ____Poor

Do you smoke? ____Yes ____No Frequency/Amount:_____

Do you exercise beyond normal daily activities?(walking, jogging, aerobics, biking, etc...) ____Yes ____No

Do you have any known allergies (latex, cortisone)? _____

Goals

What would you like to accomplish with our help? (decrease pain, improve mobility, etc...)? _____

_____

Pain Drawing

SOME PM&R PHYSICIANS HAVE THEIR PATIENTS COMPLETE A PAIN DRAWING SO THEY CAN UNDERSTAND THE LOCATION AND INTENSITY OF THEIR PAIN.

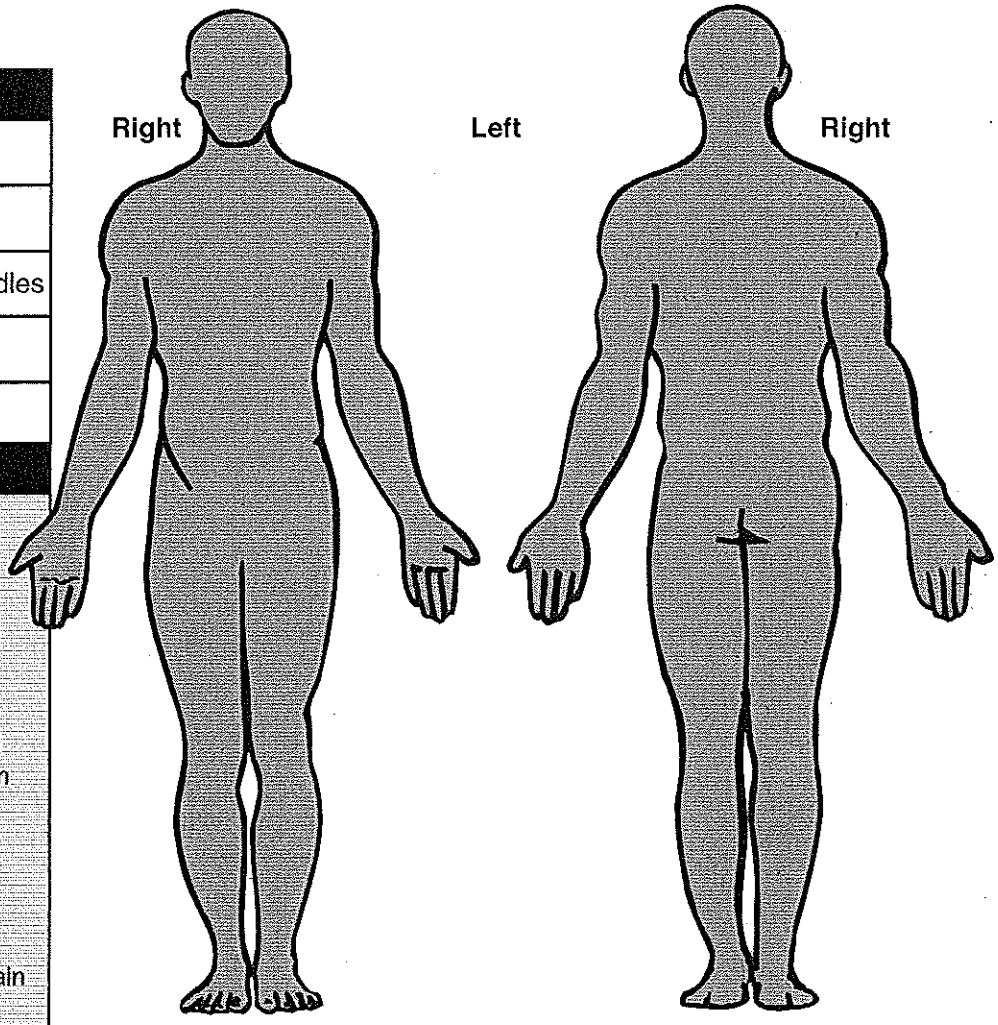
Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

☐ RIGHT HANDED

☐ LEFT HANDED

KEY	
///////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching

PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; it may make you contemplate suicide



CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10