



Professional Rehabilitation Associates, PSC
d/b/a Richmond Physical Therapy
116 Meridian Way Suite 9
Richmond, KY 40475
Phone: (859) 626-3131

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 Richmond Physical Therapy
116 Meridian Way
Richmond, KY 40475
(859) 623-3131 phone
(859) 625-1109 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
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Information to be released:

- | | | |
|-------------------------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Op Report | <input type="checkbox"/> Lab Report |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Path Report | <input type="checkbox"/> Outpatient |
| <input type="checkbox"/> H&P | <input type="checkbox"/> X-ray Report | |
| <input type="checkbox"/> Other (specify): _____ | | |

Date(s) of Service: _____

Information to be released to:

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

**PROFESSIONAL REHABILITATION ASSOCIATES, PSC
d/b/a Richmond 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)

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 _____

Neurologist _____

Dentist _____

Family physician _____

Neurosurgeon _____

Rheumatologist _____

Orthopedist _____

Pain management _____

Other: _____

MEDICAL/SURGICAL HISTORY

1. Please circle, if you have ever had:

Arthritis

Blood disorders

Lung problems

Diabetes

Multiple sclerosis

Ulcers/stomach problems

Chronic fatigue

Pacemaker

Broken bones

Circulation problems

Stroke/TIA

Low blood sugar

Tuberculosis

Skin diseases

Deafness

Other: _____

Osteoporosis

Heart problems

Cancer

Head injury

Kidney problems

Depression

Epilepsy/seizure

Thyroid problems

High blood pressure

Muscular dystrophy

Hepatitis

Repeated infections

Blindness/glaucoma

Back & or neck pain

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

Chest pain

Shortness of breath

Difficulty walking

Difficulty sleeping

Bowel problems

Headaches

Hoarseness

Dizziness/blackouts

Joint pain or swelling

Loss of appetite

Weight loss/gain

Hearing problems

Cough

Loss of balance

Pain at night

Nausea/vomiting

Urinary problems

Vision problems

Heart palpitations

Coordination problems

Weakness in arms or legs

Difficulty swallowing

Fever/sweats/chills

Other: _____

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



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)

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

SOCIAL HISTORY/LIVING ENVIRONMENT

With whom do you live?

- | | | | |
|------------------------------------------|---------------------------------------|------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Alone | <input type="checkbox"/> Spouse alone | <input type="checkbox"/> Spouse & others | <input type="checkbox"/> Personal care attendant |
| <input type="checkbox"/> Other relatives | <input type="checkbox"/> Child | Other: _____ | |

Where do you live?

- | | | | |
|---------------------------------------|------------------------------------------|--------------------------------------------------|--------------|
| <input type="checkbox"/> Private home | <input type="checkbox"/> Assisted living | <input type="checkbox"/> Long-term care facility | Other: _____ |
|---------------------------------------|------------------------------------------|--------------------------------------------------|--------------|

Does your home have:

- | | | | |
|---------------------------------------------------------|------------------------------------------|--------------------------------|-----------------------------------------|
| <input type="checkbox"/> Stairs no railing | <input type="checkbox"/> Stairs, railing | <input type="checkbox"/> Ramps | <input type="checkbox"/> Uneven terrain |
| <input type="checkbox"/> Any obstacles? Describe: _____ | | | |

Do you use:

- | | | | |
|-------------------------------|---------------------------------|--------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Walker | <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Motorized wheelchair |
|-------------------------------|---------------------------------|--------------------------------------------|-----------------------------------------------|

Employment/work (job/school/play)

- | | |
|------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Working full-time outside of home | <input type="checkbox"/> Working part-time outside home |
| <input type="checkbox"/> Working full-time from home | <input type="checkbox"/> Working part-time from home |
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Unemployed | <input type="checkbox"/> 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

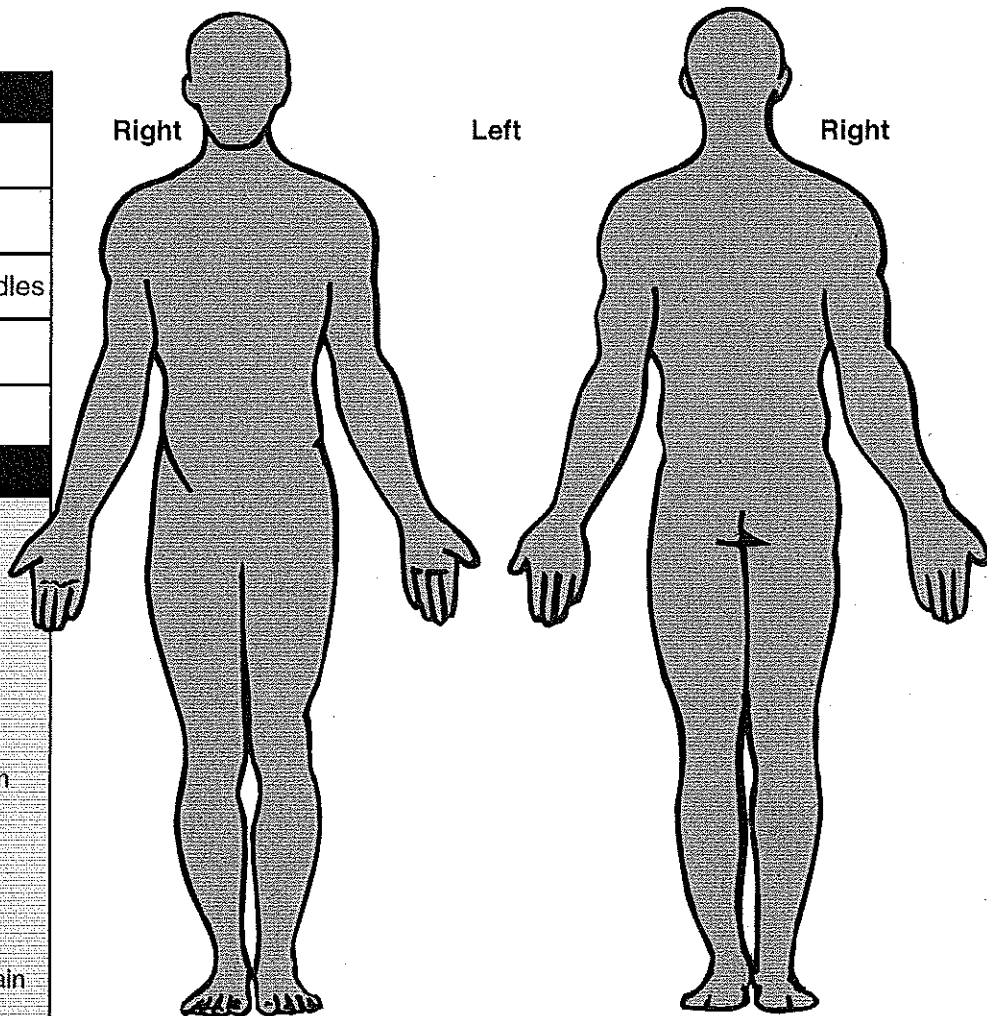
SOME PM&R PHYSICIANS HAVE THEIR PATIENTS COMPLETE A PAIN DRAWING SO THEY CAN UNDERSTAND THE LOCATION AND INTENSITY OF THEIR PAIN.

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