258 W Main Street
Camden, TN 38320
P/ (731) 584-1722
Web: www.kellykingpt.com

PATIENT INFORMATION AND HEALTH HISTORY

FIRST NAME_________________________ MI________ LAST NAME _________________________

ADDRESS ____
Street Address & P.O. Box if Applicable City State Zip

HOME PHONE __________________ WORK PHONE ___________________ ❑ MALE ❑ FEMALE

CELLPHONE___________________ DOB _____________ SS# __________________________

EMERGENCY CONTACT__________ PHONE __________________ RELATIONSHIP___________

PRIMARY CARE PROVIDER ______________________________ PHONE _________________

REFERRING DOCTOR ________________________________ PHONE _________________

DATE OF (Circle One) INJURY / CONDITION / ACCIDENT _______ DATE OF SURGERY __________

EMPLOYMENT STATUS (Check one):
❑ FT ❑ PT ❑ Retired ❑ Not Working ❑ Disability ❑ Self-Employed ❑ Homemaker ❑ Student

EMPLOYER/JOB TITLE __________________________________ EMAIL_________________

MARITAL STATUS (Check one): ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOW/WIDOWER

PRIMARY INSURANCE
WHAT IS YOUR PRIMARY HEALTH INSURANCE______________________________________

SUBSCRIBER'S NAME & RELATIONSHIP _______________________ SUBSCRIBER'S DOB ______

SUBSCRIBERS SS# ____

SECONDARY INSURANCE
WHAT IS YOUR PRIMARY HEALTH INSURANCE______________________________________

SUBSCRIBER'S NAME & RELATIONSHIP _______________________ SUBSCRIBER'S DOB ______

SUBSCRIBERS SS# ____

IS YOUR INJURY JOB RELATED? (Check one) ❑ YES ❑ NO IF YES, WHAT IS THE CLAIM # ______

FOR WORKERS COMPENSATION PATIENTS:

EMPLOYER ____

CASE WORKER/CLAIMS MANAGER ____

PHONE NUMBER ____

IS YOUR INJURY RELATED TO A MOTOR VEHICLE ACCIDENT? (Check one) ❑ YES ❑ NO

IF YES, WHAT IS THE CLAIM # ____

AUTO POLICY HOLDER ____

ADJUSTER AND PHONE NUMBER ____

OFFICE USE ONLY
Referring Physician ______________________________ Diagnosis ___________________

Injury/Illness Date ______________________________ Diagnosis Code _______________

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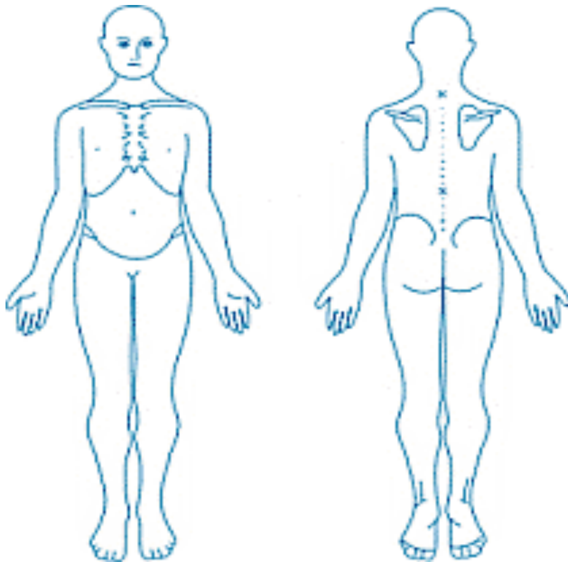
PRESENT CONDITION

Please briefly describe your symptoms:

____
____
____

Please localize your **pain** or **abnormal** symptoms/sensations by marking on the body diagram below:



When did you first notice symptoms?

____

Did your symptoms begin **gradually** or **suddenly**?
(Circle one)

How did your injury occur (if you have had surgery, please answer according to your pre-operative injury)

❑ Lifting ❑ Impact injury
❑ MVA (car accident) ❑ Dental appointment
❑ Fall ❑ Throwing
❑ Overuse (cumulative trauma) ❑ Incident at work
❑ Degenerative process ❑ Unknown
❑ During recreation/sports running
❑ Other ______________________________

Since the onset of your condition, are your symptoms getting: ❑ Better ❑ Worse ❑ No change

Have you experienced similar symptoms in the past?
❑ Yes ❑ No

More than one episode? ❑ Yes ❑ No

PATENT NAME ________________________

DATE ________________________________

HEALTH HISTORY

To insure that you receive a complete and thorough evaluation; please provide us with the most accurate, important, and up-to-date background information.

Nature of pain/symptoms:

❑ Aching ❑ Occasional ❑ Throbbing
❑ Constant ❑ Periodic ❑ Other
❑ Dull ❑ Sharp

Please rate your pain: (0- no pain, 10- Severe ER pain)

0 1 2 3 4 5 6 7 8 9 10

Since the onset of symptoms, have you experienced one of the following?

❑ Difficulty controlling bowel or bladder function
❑ Fever or chills
❑ Any numbness in the genital or anal region
❑ Numbness, dizziness or fainting attacks
❑ Weakness
❑ Unexplained weight change (loss or gain)
❑ Night pain/sweats
❑ Malaise (vague feeling of bodily discomfort)
❑ Problems with vision/hearing

What aggravates your symptoms? (Check all that apply)

❑ Sitting ❑ Repetitive activities
❑ Going to/rising from sitting ❑ Household activities
❑ Lying down ❑ Standing
❑ Walking ❑ Squatting
❑ Up/down stairs ❑ Sleeping
❑ Reaching overhead ❑ Coughing/sneezing
❑ Reaching in front of body ❑ Taking a deep breath
❑ Reaching behind back ❑ Looking overhead
❑ Reaching across body ❑ Swallowing
❑ Talking, chewing, yawning ❑ Stress
❑ Recreation or sports ❑ Sustained bending
❑ Other ________________________________

What alleviates your symptoms? (Check all that apply)

❑ Sitting ❑ Walking ❑ Heat
❑ Exercise ❑ Cold ❑ Lying down
❑ Stretching ❑ Massage ❑ Wearing a splint/orthotic
❑ Medication ❑ Rest ❑ Standing
❑ Other ________________________________

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What type of treatment have you sought for this condition?

- ❑ Medication
- ❑ Muscle/skin injections
- ❑ Joint manipulation
- ❑ Chiropractor
- ❑ Exercise
- ❑ Physical therapy
- ❑ Massage therapy
- ❑ Biofeedback
- ❑ Traction
- ❑ TENS unit
- ❑ Bracing/taping
- ❑ Spinal injection

Other ________________________________

Have you had any of the following tests for this condition?

- ❑ X-ray
- ❑ Bone scan
- ❑ CT scan
- ❑ NCS (nerve conduction study)
- ❑ MRI
- ❑ Fluoroscope
- ❑ Arteriogram
- ❑ Vestibular
- ❑ Stress x-ray test (Telos)
- ❑ Other ______________________________

Tests results ___________________________

MEDICATION

Please list any and all **prescription** medication you are currently taking:

____

____

____

Dr. who prescribed the medication ___________

Are you currently taking any of the following over-the-counter medications?

- ❑ Aspirin
- ❑ Vitamins/mineral supplements
- ❑ Tylenol
- ❑ Advil/Motrin/Ibuprofen
- ❑ Corticosteroids
- ❑ Antihistamines
- ❑ Other ______________________________

GENERAL HEALTH

How would you rate your general health?

❑ Excellent ❑ Average ❑ Poor ❑ Good fair

Do you exercise outside of normal daily activities?

- ❑ 5+ days/week
- ❑ Occasionally
- ❑ 3-4 days/week
- ❑ I do not work out
- ❑ 1-2 days/week

What do your athletic or recreational activities entail? ___________________________

____

Do you smoke?❑ Yes ❑ No ❑ Packs per day ___

Are you pregnant? ❑ Yes ❑ No ❑ months ______

PERSONAL MEDICAL HISTORY

- ❑ Cancer
- ❑ Heart Conditions
- ❑ Depression
- ❑ High blood pressure
- ❑ Stroke
- ❑ Lung Problems
- ❑ Thyroid problems
- ❑ Epilepsy/Seizures
- ❑ Diabetes
- ❑ Mental/behavioral disorders
- ❑ Multiple Sclerosis
- ❑ Rheumatoid arthritis
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Head injury
- ❑ Broken bone
- ❑ Stomach problems
- ❑ Circulation/vascular problems
- ❑ Parkinson's Disease
- ❑ Skin diseases
- ❑ Allergies
- ❑ Fibromyalgia
- ❑ Other ________________________________

Have you been exposed to any of the following?

❑ HIV/AIDS ❑ Tuberculosis ❑ Hepatitis

Please list any recent/relevant surgeries or hospitalizations:

Surgery/Hospitalization Date

____

____

____

Please list any major allergies (including food/medicine allergies):

____

____

____

FAMILY MEDICAL HISTORY

Has anyone in your immediate family ever been treated for any of the following conditions?

- ❑ Diabetes
- ❑ Cancer
- ❑ Heart disease
- ❑ Arthritis
- ❑ High blood pressure
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Psychological condition
- ❑ Other ________________________________

I, the undersigned, state that I have answered this health history completely and to the best of my knowledge:

____

Signature

____

Date

HOW DID YOU HEAR ABOUT OUR CLINIC?

❑ Newspaper ❑ Radio ❑ Physician ❑ Friend

❑ Other ________________________________

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Notice and Acknowledgment of Privacy Practices

We at PT Associates, dba King Physical Therapy, keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so or unless a legal request authorizes or compels us to do so. We will provide copies of your records to your insurance company as necessary to receive payment for our services. If you would like a copy of these records we will provide them to you for a fee of $20.00. You may see your records or get more information about them by contacting PT Associates, dba King Physical Therapy. Our **Notice of Privacy Practices** describes more in detail how your health information may be used and disclosed, and how you can access your information.

By signing below, you have acknowledged receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature **Date**

Printed name if signed on behalf of the patient **Date**

Release of Information to Designated Individuals

I authorize PT Associates, dba King Physical Therapy, to disclose my health information to the following doctor/individual(s): (Please list anyone that you would like us to release information to, including appointments, care, treatment, etc.)

I understand that the person(s) or entity(s) that receives this information may not be a health care provider or health plan covered by federal privacy regulations; the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release PT Associates, dba King Physical Therapy, its employees and my physical therapist from all liabilities arising from this disclosure of my health information.

I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire 365 days from the date signed below, I understand that I may revoke this authorization by notifying, in writing, the medical records department, knowing that previously disclosed information would not be subject to my revoke.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Patient or legally authorized individual signature **Date**

Witness **Date**

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PT Associates, dba King Physical Therapy, Policies and Procedures

Contracted and Non-contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. **If you have a co-payment, you must pay this at the time of service**. The insurance company makes the final determination of your eligibility at the time services are rendered.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract in most cases. **We will bill your primary insurance company as a courtesy to you**. Although we may estimate what your insurance may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation the person authorizing treatment for the patient will be the person responsible for those subsequent charges. If divorce decree requires the other party to pay all or part of the treatment costs, it is the authorizing party's responsibility to collect from the other party.

Service Charge: **We reserve the right to charge interest in the amount of 1.5% per month for each month payment is not received**. If you have a remaining balance after 60 days your account may be placed for outside collection. In the event that fees are incurred with the collection of my account, I will pay such costs and fees, including collection agency fees, attorney fees and all court costs. In case of suit, you agree the venue shall be in Benton County, Tennessee.

Returned Checks: **There is a fee (currently $30) for any checks returned by the bank.**

Credit History: We have the option to report your account status to any credit reporting agency such as a credit bureau.

Past due accounts: If your account becomes past due, we will take the necessary steps to collect this debt. In the event that fees are incurred with the collection of my account, I will pay such costs and fees, including collection agency fees, attorney fees and all court costs. In case of suit, you agree the venue shall be in Benton County, Tennessee.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit (including a motor vehicle accident) or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Patient or legally authorized individual signature ______________________________

Date ______________________________

King Physical Therapy Employee ______________________________