



Client History Form

Name: _____

Date: ___/___/___

DOB: ___/___/___

Gender: M / F

Age: _____ years.

Are you: ___ Right-handed ___ Left-Handed

How would you classify your general health: ___ Good ___ Fair ___ Poor

In terms of your general health, please circle **ALL** that apply:

- | | | |
|------------------------|---|--|
| Allergies | Anemia | Liver/Gallbladder Problem |
| Rheumatoid Arthritis | Recent Fever | Fibromyalgia |
| Metal Implants | Ringling of the ears | Asthma/Breathing Difficulties |
| Recent Headaches | Recent Nausea/Vomiting | Seizures/Epilepsy |
| Recent Vision Changes | Heart Attack | Recent Dizziness/Fainting |
| Sexual Dysfunction | Cancer | Recent change in bowel/bladder habits |
| Osteoarthritis | Skin Abnormalities | Pain with Cough/Sneeze |
| Heart Palpitations | Osteoporosis | Smoking History |
| Chest Pain/Angina | Hernia | Pacemaker |
| Stroke/TIA | Depression | High/Low Blood Pressure |
| Physical Abnormalities | Surgeries | Diabetes I or II |
| Hypoglycemia | Polio | Unexplained Weight Loss/Gain |
| Night Pain | Intolerance to Cold/Heat | Pregnancy (currently) |
| Urine Leakage | Recent Fractures | Recent Unexplained Fatigue |
| Kidney Problems | Heart Disease | Numbness/Tingling in Hip/Buttocks Area |
| Parkinson's Disease | Infectious Disease (TB, hepatitis etc.) | |

Is there any other information regarding your medical history or are there any factors that may complicate your ability to participate in therapy that we should know about? _____

Have you had any falls in the last 12 months? ___ Yes ___ No

If yes, please describe the nature of the fall: _____

If yes, please describe if an injury occurred: _____

Have you had any surgeries? ___ Yes ___ No If yes, please provide type and date: _____

Please list any medications you take to include dosage and frequency: (list can be attached)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Occupation: _____ Presently Working: ___ Yes ___ No

If yes, ___ Full Duty ___ Limited Duty: Restrictions: _____ # of days off work: _____

Please circle all job duties that apply to your occupation:

- | | | | | |
|----------|-------------------|--------------|-----------------|-----------|
| Sitting | Computer Work | Bending | Heavy Lifting | Traveling |
| Reaching | Crawling | Twisting | Pushing/Pulling | Walking |
| Standing | Gripping/Pinching | Other: _____ | | |

What is your current living arrangement? ___ Alone ___ Spouse ___ Partner ___ Family ___ Other: _____

Does your home have stairs? ___ Yes ___ No If yes, # of stairs: _____ Handrail? ___ Yes ___ No

Please circle any of the below devices you use:

- | | | | |
|---------|-----------------|-------------------|---------------------|
| Cane | Walker/Rollator | Manual Wheelchair | Electric Wheelchair |
| Glasses | Hearing Aid(s) | Other: _____ | |

Describe the current problem that sent you to Physical Therapy: _____

Date of next Doctor's Visit: ___/___/_____

When did your symptoms start: ___/___/_____

How did your symptoms start? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

What are your goals for PT? _____

Please list anyone else you are seeing for your symptoms: _____

Please circle any of the below clinical tests you have undergone for your symptoms:

- | | | | | |
|--------|-------------|-------------|---------|--------------------|
| Biopsy | Blood Tests | Bone Scan | CT Scan | Doppler Ultrasound |
| EEG | EKG | EMG | MRI | Myelogram |
| NCV | Spinal Tap | Stress Test | X-ray | Other: _____ |

Indicate either "yes" or "no" as to whether each of the following activities is difficult:

- | | |
|--|---|
| Sleeping through the night: Yes No | Balancing on both feet: Yes No |
| Putting on or taking off clothes: Yes No | Walking on differing surfaces: Yes No |
| Maintaining a position for a period of time: Yes No | Lifting: Yes No |
| Getting into/out of: bed, chairs, shower, car: Yes No | Carrying: Yes No |
| Reaching: overhead, forward, downward, behind back: Yes No | Bending/Kneeling/Squatting: Yes No |
| Gripping: holding tools or opening jars: Yes No | Driving a vehicle: Yes No |
| Picking up small objects: Yes No | Caring for a child or another adult: Yes No |
| Sitting: Yes No | Housework/Yardwork: Yes No |
| Standing: Yes No | Recreational Activities: Yes No |
| Job Related Activities: Yes No | Other: _____ |

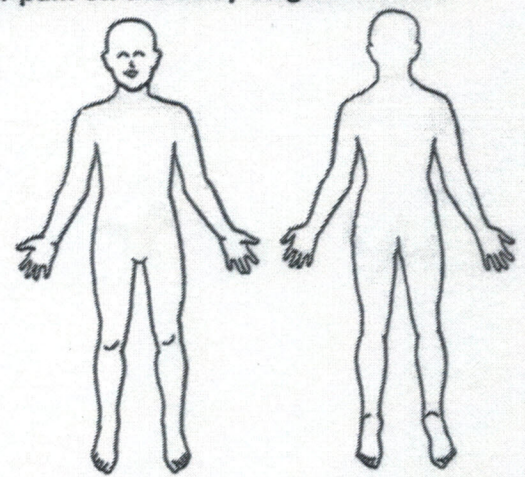
How would you describe your pain?

- | | | | | |
|--------------|-----------------|--------------|-------------|-----------------------|
| ___ Constant | ___ Come and go | ___ Ache | ___ Deep | ___ Superficial |
| ___ Dull | ___ Sharp | ___ Shooting | ___ Burning | ___ Numbness/Tingling |

When is your pain the worst? ___ Morning ___ During the day ___ at night ___ with activity ___ at rest

On a scale of 0 (no pain) to 10 (unbearable pain requiring hospitalization), how would you rate your pain:
___/10 currently ___/10 at its worst ___/10 at its best ___/10 on average

Please mark the location(s) of your pain on the body diagram below:



I consent to receive outpatient rehabilitation therapy services as deemed necessary. I am aware that the practice of rehabilitation therapy is not an exact science and I acknowledge no guarantees have been made to me regarding treatments, results, or outcomes. In conjunction with my care, I consent to allow the use of filming devices for purposes of enhancing my care and I consent to allow transmittal of such images to me and/or my treating physician via email or text.

Signature of Patient or Guardian: _____

Date: ___/___/_____



Medical Assignment of Benefits & Financial Policy

Please read and initial each of the following. Sign and date at the bottom.

Lightsey Physical Therapy is honored to be a part of your rehabilitation process and believes communication regarding our financial policy assists in providing you the best care possible. We will contact your insurance provider to obtain your current benefit coverage. However, insurance companies will not guarantee medical benefits or payment over the phone. Information gathered can only be used as a guideline.

1. I understand I have medical insurance which, when billed on my behalf, will (should) pay for my visits. This process may take several weeks/months. At that time, my insurance company will determine and pay for services according to my insurance plan benefits. _____ initial
2. I understand it is my responsibility, and agree, to pay all copays, co-insurance, deductibles, and/or cash pay estimated amounts at the time of service. _____ initial
3. I understand it is my responsibility to pay my account balance in full if at any point my physician and I elect to continue my therapy services past my approved period. _____ initial
4. I understand a copy of my explanation of benefits (EOB) will be sent to me by my insurance provider when the claims are processed. _____ initial
5. I understand it is my responsibility to pay all uncovered services within 30 days after my insurance has paid their portion. _____ initial
6. I understand if for any reason my insurance provider does not pay for the covered services within 90 days of the services provided, I will assume responsibility for the total amount owed. _____ initial
7. I understand if my account balance is not paid within 30 days from the date of my final statement, a \$50 collection fee and other fees allowable by law will be added to my account. _____ initial
8. I understand if my account balance is not paid within 30 days from the date of my final statement, my account may be referred to a collection agency. _____ initial
9. I thereby assign all medical benefits to Lightsey Physical Therapy. _____ initial
10. I authorize Lightsey Physical Therapy to release my medical information to insurance companies, physicians, attorneys and to all other pertinent parties involved in my care or claim. _____ initial.
11. I understand any returned check will result in a nonrefundable administrative fee of \$25.00. _____ initial.

I have read and understand this document and all of my questions have been answered to my satisfaction.

Patient/Guardian Signature: _____

Date: ___/___/___

Patient Name (print): _____



Patient Responsibilities/Consent

Please read and initial each of the following. Sign and date at the bottom.

1. It is the patient's responsibility to update their insurance information, address and contact information for the clinic's records. Failure to do so will result in the patient becoming responsible for all charges. _____ initial
2. It is the patient's responsibility to notify the therapist if they have been seen at another facility for physical therapy, hand therapy or speech therapy. _____ initial
3. It is the patient's responsibility to notify the therapist if their treatment is the result of an auto accident or if they were injured at work or school. _____ initial
4. It is the patient's responsibility to keep follow up appointments as scheduled. The individualized therapy program prepared for the patient requires the patient's commitment and attendance on a consistent basis to achieve optimal improvement and results. Failure to show for appointments can result in a delay of the patient's plan of care and/or discharge of services. _____ initial
5. It is the patient's responsibility to notify the office 24 hours prior to a scheduled appointment if they are unable to keep the appointment. Failure to do so will result in a **\$50.00** no show/late cancellation fee which must be paid prior to the next scheduled visit. _____ initial
6. I understand I have the right to refuse any treatments or procedures to the extent permitted by law. I understand the information from any medical record(s) maintained by this facility may be used for educational, administrative and/or facility approved purposes during which my identity will not be revealed. _____ initial
7. I understand if I do not see my physical therapist for two weeks or miss three appointments, the physical therapist may discharge my plan of care. Once I have been discharged, I understand I will need a new physician's referral/order for any further treatment and will undergo a new evaluation. This is in compliance with Texas State Law. _____ initial
8. I hereby authorize my rehab consultant to receive my records related to my injury/care. _____ initial
9. I have been provided the opportunity to review the Lightsey Physical Therapy "Notice of Privacy Practices." This document contains a description of the uses and disclosures of my healthcare information, and my rights regarding this information. Lightsey Physical Therapy displays the "Notice of Privacy Practices" in the clinic reception area. I understand Lightsey Physical Therapy has the right to change its "Notice of Privacy Practices" and that if changes are made, a revised copy of the notice will be posted in the reception area. I also understand if I have questions, or wish to receive a copy of the "Notice of Privacy Practices" I may contact the clinic. _____ initial
10. If you are a representative of the patient, check the scope of your authority to act on the patient's behalf:
___ Power of Attorney ___ Guardian ___ Parent ___ Executor of Legal Rep ___ Other _____

I have read and understand the above information. All of my questions have been answered to my satisfaction.

Patient/Guardian Signature: _____ Date: ___/___/_____
Patient Name (please print): _____



Authorization for Release of Patient Information

Patient Name: _____ Phone Number: _____
Other Names Used: _____ DOB: ___/___/___ SS#: ___-___-___
Address: _____

I, the undersigned, authorize the release of the information specified below from the medical record(s) of the above-named patient.

_____ Release to: Lightsey Physical Therapy
2651 Boonville Road, Suite 115
Bryan, Texas 77808
Phone: (979) 446-0422
Fax: (979) 446-0433

_____ I hereby authorize Lightsey Physical Therapy to release information to:

I specifically authorize the use and disclosure of the following PHI (select type and note the period of time you are requesting).

___ History and Physical _____	___ Operative Reports _____
___ Radiology Reports _____	___ Office Notes _____
___ Verbal Communication regarding health care	___ Medications _____
___ Other _____	___ Emergency Records _____

I understand I may revoke this consent at any time except to the extent that action has already been taken in reliance on it.

Patient or Guardian Signature: _____ Date: ___/___/___
Printed Name: _____ Relationship to patient: _____

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Patient name: _____ Date: _____

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer every question, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

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Therapist Use Only		
Comorbidities:	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Multiple Treatment Areas	<input type="checkbox"/> Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) <input type="checkbox"/> Obesity <input type="checkbox"/> Surgery for this Problem <input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
		ICD9 Code: