BACKGROUND INFORMATION/MEDICAL HISTORY

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you don't understand a question, leave the area blank and your therapist will assist you. Thank you!

Patient Name: _____ **Date:**_____ **Gender (circle):** M F **DOB**:_____

Patient Address:_____ **City/State:**_____ **Zip:**_____

Phone: (home)_____**(cell)**_____**Email address:**_____

Last 4 of Soc Security #_____

Emergency Contact:_____ **Emergency Contact Phone Number:**_____

Referring MD:_____ **Referring MD Phone Number:**_____

How were you referred to Functional Capacity Institute, LLC:_____

Is your injury/condition a result of a work-related incident? □ Yes □ No

WORKERS' COMPENSATION ONLY

Insurance Company:_____

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

Claim #_____ **Date of Injury/Accident:**_____

Insurance Adjuster: _____ **Ins. Adjuster Phone Number:** _____

Employer:_____ **Employer Phone Number:**_____

Case Manager:_____ **Case Manager Phone Number:**_____

Attorney:_____ **Attorney Phone Number:**_____

I, _____hereby authorize and instruct my workers' compensation insurance carrier to pay Functional Capacity Institute, LLC directly for any medical services performed. Additionally, I understand I am financially responsible for payment of all balances not covered by my workers' compensation insurance carrier. All non-workers' compensation services will be paid on a self-pay basis.

I understand if I default on my account, it may be sent to collections, which may result in additional charges. If I am the legal guardian of the patient named above, I accept responsibility for the above. I authorize the release of any medical records to my insurance carrier for the purpose of expediting claim payment.

Insured or Authorized Person's Signature_____ Date:_____

Are you currently: (please check one)

□ Working at your usual job without restrictions □ Unable to work because of your condition.
□ Off work since _____ □ Working at your usual job with restrictions □ Retired □ Unemployed

What is your **primary reason** for today's appointment?_____
Please briefly describe your symptoms :_____
_____
Date of Injury: _____

Have you ever seen a physical therapist for this problem? □ Yes □ No

Are you currently seeing any of the following? (please check all that apply)
□ Medical Doctor (M.D.) □ Psychiatrist/Psychologist □ Osteopath □ Physical Therapist □ Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.): _____

_____

Past surgical history (type & date of surgery):

_____

_____

Have you EVER been diagnosed as having any of the following conditions (check all that apply)?

□ Heart problems	□ Circulation problems	□ Bladder/UTI	□ High blood pressure
□ Asthma	□ Kidney problem	□ Emphysema/Bronchitis	□ Thyroid problems
□ Chemical dependency	□ Rheumatoid arthritis	□ Diabetes	□ Bone/joint infection
□ Multiple sclerosis	□ Pelvic Disease	□ Epilepsy	□ Anemia
□ STD and/or HIV	□ Lung disease	□ Depression	□ Cancer
□ Hepatitis	□ Tuberculosis	□ Stroke	□ Ulcers
□ Past pregnancy (circle one):Vaginal or Cesarian		□ Osteoporosis	□ Blood clots
□ Liver problems		□ Chest pain/angina	
□ Current pregnancy : # of mos:____		□ Other : _____	

List allergies to medications or Latex: _____

Please list any medication you are currently taking:_____

Have you RECENTLY noted any of the following (CIRCLE: YES or NO) ?

YES NO Bladder irregularities **YES NO** Nausea / vomiting **YES NO** Fatigue
YES NO Numbness or tingling **YES NO** Fever / chills / sweats **YES NO** Falls
YES NO Weight loss/gain

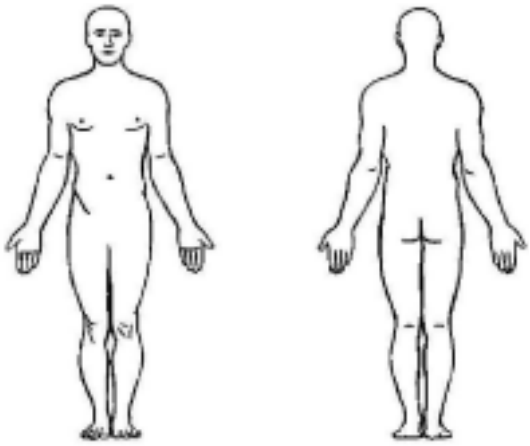
Do you smoke **YES NO** If yes, how many cigarettes per day?_____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symptoms to describe your symptoms:

▌ Shooting/Sharp pain ||| Numbness

○ Dull/aching pain = Tingling



On the scales below, please circle the number (0-10) which best represents the severity of your pain:

***CURRENT LEVEL OF PAIN*:**
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

***USUAL LEVEL OF PAIN during the past week*:**
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

BEST (LEAST) LEVEL OF PAIN during the past week:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

WORST (MOST) LEVEL OF PAIN during the past week:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Form reviewed with patient? □ YES □ NO Therapist initials :_____Date_____

PATIENT COMMUNICATION PREFERENCES

Do you prefer text or call reminders? Yes No

Please check all that apply: ☐ Text ☐ Call ☐ Email

By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, your personal exercise program, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

Patient Signature _____ Date_____

Patient Information Consent Form

Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Functional Capacity Institute, LLC. The physical therapist will explain the nature and purposes of the evaluation, procedures, and course of treatment. The physical therapist will inform me of the expected benefits and complications, and any discomforts and risks that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Assignment of Benefits and Insurance Proceeds

I authorize payment of medical benefits to Functional Capacity Institute, LLC for services rendered. Functional Capacity Institute, LLC, will make reasonable effort to collect workers' compensation insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy. All non-workers' compensation services will be paid on a self-pay basis.

Patient Information Consent Form (HIPAA)

I have read and fully understand Functional Capacity Institute LLC's Notice of Information Practices. I understand that Functional Capacity Institute, LLC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Functional Capacity Institute, LLC will consider requests for restrictions on a case by case basis but is not required to oblige to such requests.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Functional Capacity Institute, LLCs Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Functional Capacity Institute, LLC has 30 days to respond to my request.

Release of Information

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Designated Individuals Authorization

I, _____, hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print "none" below.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I have read and understand the above consents, assignment of benefits, release of information, and designated individual's authorization above.

Patient Signature _____ Date_____