



Important Information

Please read the following and sign below to acknowledge that you understand and agree to the following:

CONSENT TO TREAT

The undersigned grants authority to South Aiken Physical Therapy, LLC (SAPT) and its staff to perform procedures and treatments deemed necessary for this patient and generally are used in the care of patients in this and similar Physical Therapy facilities. Additionally, the undersigned grants permission for the SAPT staff to provide emergency treatment if it is needed, or to transfer this patient to a local hospital for emergency treatment deemed necessary by the hospital medical staff.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The undersigned acknowledges that he/she has been provided the option to receive a copy of the South Aiken Physical Therapy Notice of Privacy Practices. I understand that SAPT has the right to change its Notice of Privacy Practices and that I may contact SAPT at any time to obtain a current copy of the Notice of Privacy Practices.

ASSIGNMENT OF INSURANCE BENEFITS (CHECK ONE)

O I AM PAYING CASH FOR MY SERVICES. THIS DOES NOT APPLY TO ME

O I WANT YOU TO DEAL DIRECTLY WITH MY INSURANCE

The undersigned hereby instructs and directs my insurance company to pay by check made out and mailed to: South Aiken Physical Therapy, 943 Pine Log Road, Aiken, SC 29803. This is a direct assignment of my rights and benefits under my policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I agree that: a photocopy of this Assignment shall be considered as effective and valid as the original, I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster or attorney involved in this case for the purpose of processing claims and securing payment of benefits, I authorize the use of this signature on all insurance submissions, I authorize South Aiken Physical Therapy, LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf, I understand that I am financially responsible for all charges whether or not paid by insurance. ***If Policy Holder is different than patient please provide the following information:***

Policy Holder Name _____ Policy Holder Date of Birth: _____

PLEASE SIGN:

Signature of Patient (Required)/Date

Signature of Representative (Where Required)/Date

Office Use Only:

Initials: _____ Date: _____

Welcome! To help us deliver you the very best care possible please fully complete this questionnaire.

Patient Name: _____ Date of Birth: _____

What is the main problem we are seeing you for today? _____

When did this problem start? _____

Did you have surgery for this problem? Yes No If yes, when? _____

What procedure? _____

Of the following activities and tasks listed below, which are difficult to do or are you unable to do because of your current problem?
 Please check the applicable box(es).

- | | |
|---|---|
| <input type="radio"/> Dressing | <input type="radio"/> Remaining Standing |
| <input type="radio"/> Bathing | <input type="radio"/> Squatting |
| <input type="radio"/> Toileting | <input type="radio"/> Kneeling |
| <input type="radio"/> Sleeping | <input type="radio"/> Sitting |
| <input type="radio"/> Driving | <input type="radio"/> Standing |
| <input type="radio"/> Ability To Handle Phone | <input type="radio"/> Move From Bed To Chair |
| <input type="radio"/> Cooking | <input type="radio"/> Turning In Bed |
| <input type="radio"/> Laundry | <input type="radio"/> Rising From A Chair |
| <input type="radio"/> Volunteer | |
| <input type="radio"/> Caregiving | |
|
 | |
| <input type="radio"/> Need For Assistive Device | <input type="radio"/> Pulling Objects |
| <input type="radio"/> Walking Forward, Back Or Sideways | <input type="radio"/> Pushing Objects |
| <input type="radio"/> Walking Around Obstacles | <input type="radio"/> Reaching |
| <input type="radio"/> Climbing | <input type="radio"/> Turning Or Twisting Hands Or Arms |
| <input type="radio"/> Running/Jogging/Skipping/Jumping | <input type="radio"/> Throwing |
| <input type="radio"/> Swimming | <input type="radio"/> Catching |
| <input type="radio"/> Walk In Home | <input type="radio"/> Picking Up Small Items |
| <input type="radio"/> Stairs | <input type="radio"/> Gripping Objects |
| <input type="radio"/> Walk In Community | <input type="radio"/> Manipulating Small Items |
| <input type="radio"/> Walk In Large Building | <input type="radio"/> Releasing Small Objects |
| <input type="radio"/> Walking On Uneven Terrain | <input type="radio"/> Kicking |
| | <input type="radio"/> Work |
| | <input type="radio"/> Wellness/Recreation |

Did you have difficulty with any of the above activities before this problem? Yes No If yes, please explain below:

If we are seeing you for a pain problem today, please tell us more about it:

Where is your pain? _____

How would you rate your pain on a scale of 0-10 (0 is no pain, 5 is moderate pain, 10 is excruciating pain)?

At Worst _____, Currently _____, At Best _____

Describe your pain further by checking all applicable descriptions:

- | | | |
|------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Shooting | <input type="checkbox"/> Worse in AM |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numb/Tingle | <input type="checkbox"/> Worse in PM |
| <input type="checkbox"/> Dull/Achy | <input type="checkbox"/> Constant | <input type="checkbox"/> Worse at Night |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Intermittent | Other: _____ |

How would you describe your general health? Good Fair Poor Other: _____

Please tell us more about your Medical History. Please check any that apply:

- | | |
|---|---|
| <input type="checkbox"/> I have no Known past medical history to affect treatment | <input type="checkbox"/> History of Cancer |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Immunosuppression |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Traumatic Brain Injury |
| | Other: _____ |

If you have had any diagnostic tests for this problem please note results here: (i.e. Xray, MRI, CT scans)

Do you have any unexplained weight loss? Yes No

Are you currently taking any medications (prescription, herbal or over the counter)? Yes No
 If yes please list below or provide a list. I have provided a separate medication list

List one or two things you are having difficulty doing now that you would like to be able to do better after Physical Therapy;

1. _____

2. _____

 Signature (parent/guardian if under 18)

 Date

OFFICE USE ONLY: Height (inches) _____ Weight (pounds) _____ Source: SAPT / MR
 Blood Pressure _____ Patient refuses height and weight measurement
 (N = Age 65 & older BMI ≥ 23 and < 30 kg/m² ; Age 18 – 64 BMI ≥ 18.5 and < 25 kg/m²)