KODA
PHYSICAL THERAPY

New Patient Information

Name:______________________________ Today's Date: ____________

DOB:______________________________ S.S#: ___ ___ ___ Referring MD:______________

Address:______________________________ E-mail:______________________________

Home phone: Work: Cell: Employer:______________________________

Name:________________ Phone: Work Address:______________________________
Emergency contact

TELL US ABOUT YOUR INJURY & GOALS

Is your injury work-related? ◯Yes ◯No

If yes, please explain:______________________________

____

____

Briefly describe your current complaints or limitations:

____

____

Were you hospitalized for this condition? ◯Yes ◯No

Is your physician aware of this condition? ◯Yes ◯No

Date you last saw your physician: ____________

Do you currently have any other pertinent medical conditions? ◯Yes ◯No

If YES, please list:

______________ ______________

______________ ______________

List any medications you are currently using:

______________ ______________

______________ ______________

______________ ______________

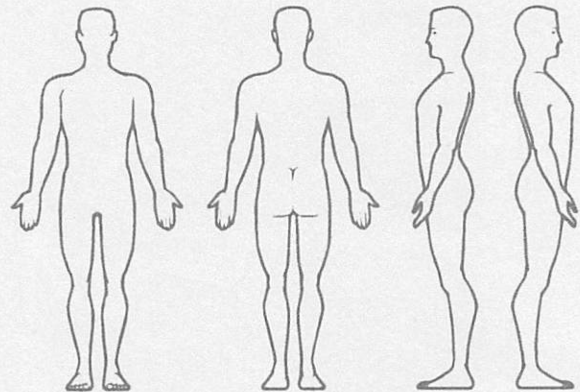
What is(are) your goal(s) for therapy?

____

____

PAIN/SYMPTOMS

Please indicate where you are experiencing symptoms?



Please describe the quality of your pain:

(Mark only those which apply)

◯ Dull/Aching Sharp ◯ Numbness
◯ Shooting ◯ Burning
◯ Throbbing ◯ Superficial
◯ Tingling ◯ Deep

What is your pain level at rest?

0=No Pain 10=Worst pain you could imagine

0 1 2 3 4 5 6 7 8 9 10

What is your pain level when active?

0 1 2 3 4 5 6 7 8 9 10

What is the frequency of your pain?

◯ Constant (76-100%) ◯ Occasional (26-50%)
◯ Frequent (51-75%) ◯ Intermittent (25%)

CHRONOLOGY/TIMING OF SYMPTOMS:

How long have the symptoms been present?

____days____months____years or date:____/___/_____

How did your symptoms begin?_______________

____

____

Did you have surgery? ◯Yes ◯No

Facility:_______________________________

Have you been treated for this issue in the past?

◯Yes ◯No

If Yes, then by whom?_______________

MD:_______________________________

Physical Therapist: _______________

Chiropractor: _______________

Other:_______________________________

Pain pattern since onset:

◯ Better ◯ Worse ◯ Same ◯ Fluctuating:

Pain/Symptoms improve:

◯ Morning ◯ Midday ◯ Evening ◯ Night

Pain/Symptoms Worsen:

◯ Morning ◯ Midday ◯ Evening ◯ Night

Which of the following make symptoms feel better?

◯ Nothing ◯ Lying down ◯ Standing

◯ Sitting ◯ Inactivity ◯ Movement/Exercise

Which of the following make symptoms feel worse?

◯ Nothing ◯ Lying down ◯ Standing

◯ Sitting ◯ Inactivity ◯ Movement/Exercise

SPORTING/LEISURE ACTIVITIES:

Type:_______________________________

Frequency: _______________________________

Allergies:

Type:_______________________________

____

Frequency: _______________________________

WORK HISTORY:

Occupation:_______________________________

◯ Full-time ◯ Part-time

Has work-status changed since onset of symptoms?

◯Yes ◯No

Are you currently working? ◯Yes ◯No

Restrictions (if any)?_______________

Do you have a permanent disability rating? ◯Yes ◯No

If Yes:_________Location ___/___/___Date _____% Rating

MEDICAL HISTORY:

Height:_______ **Weight:**_______

Have you ever had any of the following conditions?

◯ High blood pressure

◯ Angina

◯ Heart Attack

◯ Shortness of breath

◯ Dizziness/lightheadedness

◯ Pain/heavy sensation in the chest

◯ Constant or severe pain in the lower leg (calf)

◯ Pulsating pain anywhere in the body

◯ Stroke

◯ Asthma

◯ HIV/AIDS

◯ Cancer Location:_____________ Date: ___/___/___

◯ Persistent pain at night

◯ Constant pain anywhere in the body

◯ Unexplained weight loss (10-15lbs in 2 weeks)

◯ Frequent or severe abdominal pain

◯ Changes in bowel or bladder function

◯ Systemic lupus

◯ Hepatitis

◯ Epilepsy

◯ Diabetes ◯ Type 1 ◯ Type 2

◯ Rheumatoid arthritis

◯ Raynauds

◯ Pregnancy

◯ Other:

◯ Coffee/Tea/Caffeinated drinks:____cups/cans per day

◯ Tobacco:____ pack(s) per day

◯ Alcohol:____drinks(s) per week

◯ Drug or alcohol dependence

KODA PHYSICAL THERAPY & SPORTS PERFORMANCE
1600 Corporate Circle · Petaluma · CA · 94954
OFFICE 707·981·8604 · FAX 707·981·8647

No Show/Late Cancellation Policy

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-show and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-show and late-cancellation delay the delivery of health care to other patients.

A “No show” is missing a scheduled appointment. A “late cancellation” is canceling an appointment without calling 24 hours in advanced.

We understand that situations such as medical emergencies occasionally arise. As such, these situations will be considered on a case-by-case basis.

A charge of $40.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hours notice is given.

This charge is solely the patient responsibility and will not be billed to the insurance company.

____________________ ___________________________________
DATE SIGNATURE

KODA Physical Therapy and Sports Performance
1600 Corporate Circle. Petaluma, CA 94954

phone: 707-981-8604
fax: 707-981-8647

Assignment of Benefits

I hereby authorize the payment of medical benefits directly to KODA Physical Therapy and Sports Performance for services rendered. I further authorize the release of health care information provided by the physical therapist to my insurance company or their agents for the purposes of administering claims and benefits. **I agree that I am financially responsible for all balances not paid by my insurance company.**

Benefit information obtained by KODA Physical Therapy and Sports Performance as a courtesy is not a guarantee of benefits or payment. **The patient is encouraged to contact their insurance company to obtain benefit information themselves.**

The billing process can take up to 60 days to reconcile with your insurance company. Please be aware that you are incurring expenses during your treatment and you are responsible for any fees not picked up by your insurance company. **We ask that any portion that that is your responsibility be paid within 60 days of your last appointment with us.** Other arrangements can be made with the owner or office manager if necessary.

#_______ Number of physical therapy, occupational therapy or chiropractic therapy used elsewhere at another office this benefit year.

X_____________________________________ X_______________
Signature (Patient or Parent of minor) Date

Auto Accident? (please circle) Yes No Date of accident:_____________

_________________________________ _________________________________
Auto insurance company name Phone

_________________________________ _________________________________
Auto insurance address Adjustor name

IF THERE IS ANY POSSIBILITY THAT THIS IS WORK RELATED, PLEASE INFORM THE OWNER OR OFFICE MANAGER RIGHT AWAY!!!

I ATTEST THAT I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED TO ME BY   REGARDING THE HIPPA (Health Insurance Privacy and Portability Act) REQUIREMENTS.

____
SIGNATURE

____
DATE

KODA Physical Therapy and Sports Performance

Loren Kimble, PT, DPT

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