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:

_____ _____

_____ _____

_____ _____

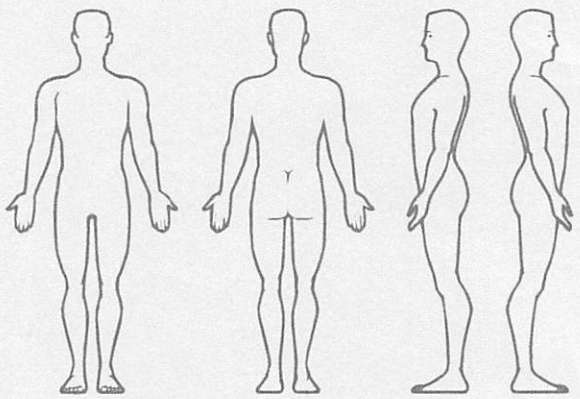
What is(are) your goal(s) for therapy?

_____

_____

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
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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

WORKERS COMPENSATION INSURANCE AGREEMENT

Claimants Name_____

Claimants Address_____

Employer_____

Employers Address_____

Insurance Carrier_____

Address_____

Claim #_____ Phone#_____

Date of Accident_____ **Adjuster**_____

1. Our office is pleased to accept your Workers Compensation. We will file your claim forms and assist you in every way we can.
2. It is a **CA State regulation that you must receive a Referral from your doctor** for physical therapy treatment. **This is your responsibility**, however we will assist you in that process. **If you do not have an updated referral, we will not be able to continue your treatment.**
3. In the event that you fail to prosecute the claim for Workers Compensation for this illness or condition, or, if the claim is determined by the appropriate insurance carrier that benefits for this illness or condition are denied, you will be responsible for payment of your usual and customary fees.
   a. It must be fully understood that the contract for coverage is between you and your insurance carrier.
   b. Our office WILL NOT enter into a dispute with your insurance carrier over your claim. This is your responsibility and obligation. However, we will assist you wherever possible.
   c. Your insurance should pay within 30 days. However, if your outstanding balance exceeds $1500.00 or your insurance carrier has not paid in 90 days (whichever comes first) we will have to interrupt your treatment until payment is received.
   d. If you understand and agree with all of the above office policies, please sign below and we will accept your insurance assignment.

_____ _____

Signature Date

____Patient consult, welcome pkt _____review appointment policy _____RX's

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

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