Greenwood Physical Therapy

Patient Medical History

Name: _____ Referring Physician: _____

Family Physician: _____ First Doctor Visit for Injury: _____

Last date worked due to injury: _____ Date returned to work after injury: _____

Is there an attorney involved in this case? _____ Date of next Doctor visit: _____

Have you had surgery for this injury? _____ Number of Surgeries: _____ Date(s): _____

Type of Surgery: _____

Where did your surgery take place: _____

Current Level of Pain (0 being no pain, 10 being pain requiring Emergency Room Care)

(Circle only one) 1 2 3 4 5 6 7 8 9 10

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATION: _____

If yes, please list: _____

PLEASE CHECK ANY OF THE FOLLOWING MEDICAL OR REHABILITATIVE SERVICES YOU HAVE RECEIVED FOR THIS CONDITION

____Orthopedist	____ Physical Therapy	____ X-Rays	____ EMG
____ Occupational Therapy	____ CT Scan	____ NCV	____ Neurologist
____ Massage Therapy	____ MRI	____ Injection	____ General Practitioner
____ Myelogram	____ Cast or Brace	____ Emergency Room Care	
____ Chiropractor	____ Other _____		

PLEASE CIRCLE ANY OF THE FOLLOWING ITEMS THAT PERTAIN TO YOUR HEALTH HISTORY

Asthma	Sleeping Problems	Allergies	Shortness of Breath
Emotional	Psychological	Anemia	Coronary Heart Disease
Headaches	Infectious Disease	Chest Pain	Numbness or Tingling
Neurological Problems	Do you have a Pacemaker?	Dizziness or Fainting	Diabetes
High Blood Pressure	Blurred Vision	Metal Implants	Heart Attack
Ringing in the Ears	Cancer	Heart Surgery	Weakness
Do you Smoke?	Epilepsy or Seizures	Arthritis or Swollen Joints	Blood Clot or Emboli
Night Sweats/Pain	Are you Pregnant?	Hernia	Osteoporosis
Thyroid Trouble	Urinary Problems	Recent Fever	Pain Unrelieved by position or rest
Varicose Veins	Stroke/TIA (Date) _____	Alcohol/Drug Dependence	Abnormal Weight Gain/Loss

Other: _____

PLEASE LIST ANY SURGERIES YOU HAVE HAD IN THE PAST: _____

_____

PLEASE LIST THREE GOALS YOU WOULD LIKE TO ACHIEVE WHILE IN THERAPY:

1. _____
2. _____
3. _____

EMERGENCY CONTACT: _____ PHONE: _____

PATIENT OR GUARDIAN SIGNATURE: _____ Date: _____

Greenwood Physical Therapy

Patient Name: _____ DOB: _____

GENERAL CONSENT AND ACKNOWLEDGEMENT

CONSENT FOR DIAGNOSIS, CARE AND TREATMENT

I understand and acknowledge that this General Consent and Acknowledgement applies to care and treatment I receive at Greenwood Physical Therapy.

I consent to and authorize the physical therapists and other health care providers who may be involved in my care to provide such diagnosis, care and treatment considered necessary for the care I am seeking or as may otherwise be advisable for my well being. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at Greenwood Physical Therapy. I understand that health care providers in training, including students, may be involved in my care and treatment and I consent to their involvement in my care. I understand that if I leave the practice without the consent of the physician and/or fail to carry out instructions for follow-up care; I do so at my own responsibility. I further understand that any injury or harm I may suffer while away from Greenwood Physical Therapy will be my responsibility.

_____ Initial

USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that Greenwood Physical Therapy will use and disclose my health information for the purposes of treatment, payment, and healthcare operations. I understand, acknowledge and consent to the release of my personal health information for the purposes outlined in this section, as described in the Notice of Privacy Practices which has been offered to me, and as may otherwise be permitted by law.

_____ Initial

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Greenwood Physical Therapy's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I may request a copy of any amended Notice of Privacy Practices at each appointment. In accordance with the policy there will be no electronic devices allowed in the gym area. I understand the information Greenwood Physical Therapy acquires or creates about me will only be disclosed to others for treatment, payment and health care operations as set forth in the notice or as authorized by me in writing.

_____ Initial

268 Greenwood Ave
Suite 202
Bethel, CT 06801
Phone 203-917-4792 * Fax 203-917-4798

Greenwood Physical Therapy

Patient Name: _____ DOB: _____

CANCELLATION AND NO SHOW POLICY

Your physician has recommended physical therapy to remedy the condition that is affecting you; therefore it is absolutely necessary that you attend all of your scheduled appointments. Your therapist will advise you at your evaluation how many times a week it will be necessary for you to attend. ALL appointments missed MUST be made up in the same week so you may fully recover. Greenwood Physical Therapy requires 24 hours notice for any cancellation. If you do not give 24 hour advance notice for any cancellation or you do not show for your scheduled appointment an administrative fee of $25 will be billed to you.

_____ Initial

ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT

I guarantee payment of all charges incurred for services rendered by Greenwood Physical Therapy for the patient name on the top of the page. I guarantee the amount due for non-insurable charges including co-payment, deductibles, etc. If private health insurance, Medicare, Medicaid, other governmental or other insurance programs cover my treatment, I authorize Greenwood Physical Therapy to bill any such insurer for all charges incurred by me in connection with my diagnosis, care and treatment. I, as the responsible party, agree to furnish Greenwood Physical Therapy with up-to-date insurance. Any changes in insurance coverage must be reported to the office immediately. If my insurance plan requires a referral for me to come to Greenwood Physical Therapy, I understand that I am responsible for securing that referral. I further acknowledge that failure to do so may mean that I will not be seen upon arrival at the office. Acceptable methods of payment are cash, check or any card except AMEX.

_____ Initial

_____ _____

Signature of Patient or Responsible Party if Minor *Date*

_____

Please print name of patient

268 Greenwood Ave
Suite 202
Bethel, CT 06801
Phone 203-917-4792 * Fax 203-917-4798

Greenwood Physical Therapy

Date: _____ Patient Name: _____

Dizziness Handicap Inventory

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please check "yes", or "no" or "sometimes" to each question. *Answer each question only as it pertains to your dizziness or unsteadiness.*

Item #	Question		Y	N	S
1	Does looking up increase your problem?	P			
2	Because of your problem, do you feel frustrated?	E			
3	Because of your problem, do you restrict your travel for business or recreation?	F			
4	Does walking down the aisle of a supermarket increase your problem?	P			
5	Because of your problem, do you have difficulty getting into or out of bed?	F			
6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing or to parties?	F			
7	Because of your problem, do you have difficulty reading?	F			
8	Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?	P			
9	Because of your problem, are you afraid to leave your home without having without having someone accompany you?	E			
10	Because of your problem have you been embarrassed in front of others?	E			
11	Do quick movements of your head increase your problem?	P			
12	Because of your problem, do you avoid heights?	F			
13	Does turning over in bed increase your problem?	P			
14	Because of your problem, is it difficult for you to do strenuous homework or yard work?	F			
15	Because of your problem, are you afraid people may think you are intoxicated?	E			
16	Because of your problem, is it difficult for you to go for a walk by yourself?	F			
17	Does walking down a sidewalk increase your problem?	P			
18	Because of your problem, is it difficult for you to concentrate?	E			
19	Because of your problem, is it difficult for you to walk around your house in the dark?	F			
20	Because of your problem, are you afraid to stay home alone?	E			
21	Because of your problem, do you feel handicapped?	E			
22	Has the problem placed stress on your relationships with members of your family or friends?	E			
23	Because of your problem, are you depressed?	E			
24	Does your problem interfere with your job or household responsibilities?	F			
25	Does bending over increase your problem?	P			
			x4	**x0**	**x2**
		=			
		TOTAL			

P= _____ **E=** _____ **F=** _____

□ **100-70**=severe perception of having handicap, □ **69-40**=moderate perception of having handicap, □ **39-0**=low perception of handicap