RESTORE
PHYSICAL THERAPY

Thank you for choosing **RESTORE Physical Therapy. Our Mission** is: ***We Strive to Empower People to Live Healthy and Active Lives***. If you have any questions regarding your first appointment please visit our web site at www.restore-rehab.com and listen to the *First Visit* video or go to the FAQ section.

Our new patient appointments run on time, **please arrive 10 to 15 minutes prior** to your scheduled appointment, hand in your completed paper work and review your registration form. If you wait to complete your paperwork at our office, please arrive 30 minutes in advance. If you arrive exactly at your scheduled visit time for you first session, this may either inconvenience you because your visit may need to be cut short or the patient who follows you. Also, if you need to **cancel** or change your first appointment, please provide **at least 24 hours** notice.

We look forward to participating in your care. Please see **RESTORE's** Promises and Expectations below.

We promise to:

- Welcome you into a caring and professional environment.
- Listen with respect and respond to your concerns.
- To inform you the cost of treatment in advance.
- Do our absolute best to keep your appointment on time.
- Perform our very best standard of physical therapy for you at all times.
- Make no charges for appointments changed or cancelled where 24 hours notice has been given.

We appreciate your commitment to:

- Arrive on time for your appointments.
- Sign-in upon arrival each visit and wait to be brought back to your treatment area.
- **Give at least 24 hours notice if for some reason you need to cancel or change your appointment to avoid a cancellation charge.**
- Follow our instructions for follow-up exercises.
- Attend review and maintenance appointments as advised.
- Pay for treatment, as required, prior to each visit. We accept cash, personal checks, debit cards and credit cards (Visa, MasterCard, Discover).
- Talk to us. Let us know what you think of what we do, right or wrong.

Help our practice grow by recommending us to your family, friends and colleagues.

Please print the attached forms, complete and bring them with you to your first visit to speed your initial appointment's registration process.

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MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: ____/____/____ Date: ____/____/____

Are you presently working? ☐ Yes ☐ No; Occupation:_____ Last Day Worked: _____/_____/____

Work Status: ☐ Regular Duty ☐Restricted/Light Duty ☐ Out of Work ☐ Retired ☐ Student ☐ N/A

Have you participated in physical therapy over the last year? ☐ Yes ☐ No; If yes, how many visits? _____

Have you fallen over the past year? ☐ Yes ☐ No; If yes, how many times? _____

Date of next physician's visit: _____/_____/_____

Check which apply to your symptoms or injury:

☐ work related injury	☐ recurrence of previous injury	☐ chronic condition
☐ motor vehicle accident	☐ injury related to lifting	☐ injury related to a slip or fall
☐ cause unknown	☐ athletic / recreational injury	☐ other: _____

Do you have an attorney for this injury? ☐ Yes ☐ No; Attorney Name: _____ Phone Number: _____

Date of injury/onset: _____/_____/_____ Have you ever had physical therapy for these symptoms before? ☐ Yes ☐ No

Have you had a surgery for this condition? ☐ Yes ☐ No ; Date: _____/_____/_____ Briefly explain below:

Have you been hospitalized for this condition? ☐ Yes ☐ No ; Dates: _____/_____/_____ to _____/_____/_____

Have you had home care services for this condition? ☐ Yes ☐ No ; Date of discharge: _____/_____/_____

_____

_____

Do you have, or have you had any of the following? (Must check either Yes or No, Do not leave any blank)

	Yes	No		Yes	No
Diabetes: Type 1 Type 2	☐	☐	Allergies to Aspirin	☐	☐
Chest / Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies:	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Stroke/CVA	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fracture	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Sexual Dysfunction	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Nausea/ Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma / Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Special Diet Guidelines	☐	☐
Smoker	☐	☐	Hypoglycemia	☐	☐
Headaches	☐	☐	Other:	☐	☐
X-ray	☐	☐	MRI/CAT Scan	☐	☐
EMG	☐	☐	Bone Scam	☐	☐

If you answered yes on any of the above, please briefly explain and give the approximate dates and results:

_____

_____

_____

_____

Patient Name: _____ Date of Birth: ____/____/____ Date: ____/____/____

Is there any other information regarding your past medical history that we should know about?

_____

_____

Are you presently taking Medication? ☐ Yes ☐ No

If yes, please list what medications (dosage and frequency) and for what condition: (All four must be completed for each medication)

Medication: _____ Dosage: _____ Frequency: _____ Condition: _____

Medication: _____ Dosage: _____ Frequency: _____ Condition: _____

Medication: _____ Dosage: _____ Frequency: _____ Condition: _____

Medication: _____ Dosage: _____ Frequency: _____ Condition: _____

Medication: _____ Dosage: _____ Frequency: _____ Condition: _____

Medication: _____ Dosage: _____ Frequency: _____ Condition: _____

Medication: _____ Dosage: _____ Frequency: _____ Condition: _____

Medication: _____ Dosage: _____ Frequency: _____ Condition: _____

Medication: _____ Dosage: _____ Frequency: _____ Condition: _____

Medication: _____ Dosage: _____ Frequency: _____ Condition: _____

In case of an emergency, whom should we contact?

Name: _____ Relationship to patient:_____

Phone Number: _____

Prior to your injury, did you participate in any sports, exercise programs or activities on a regular basis?

☐ Yes ☐ No If yes, please describe.

_____

_____

If you work, how would you rate your work activity? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

_____ ____/____/____ _____

Patient's Signature Date Signature of Guardian if patient is a minor

I have reviewed the present and past medical history with the patient.

_____ ____/____/____

Therapist Signature Date

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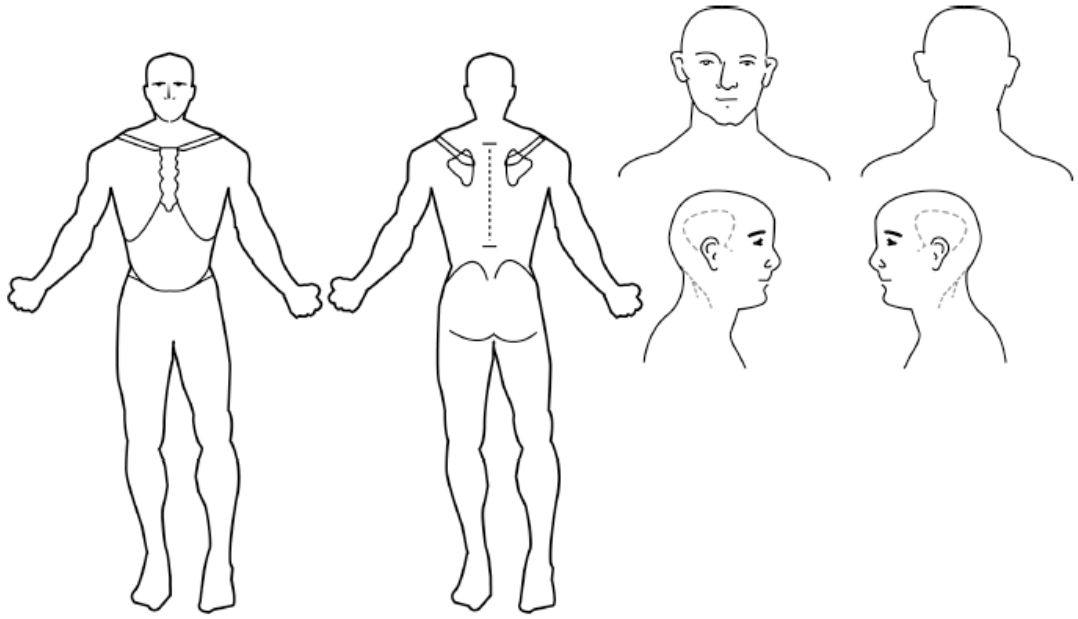
Patient Name: _____ Date of Birth: ____/____/____ Date: ____/____/____

Please indicate below where your symptoms are located. Use **X** marks where you have pain and //// marks to show where you feel numbness, tingling or pins and needles **TODAY**.



If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain imaginable. Please answer all three questions below. (Please circle number)
Please consider worse is worse and least is least even if you are doing no activity.

Please rate your **worse** pain over the last 3 days.

No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Worst Pain Possible

Please rate your **current** pain.

No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Worst Pain Possible

Please rate your **least** pain over the last 3 days. (Includes when at rest)

No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Worst Pain Possible

Which best describes the pain you have mostly: (Please Circle) None , Dull/Aching, Sharp, Throbbing, Burning, Numbness, Tingling, Constant, Intermittent, Radiating

If 100% is your goal (where you **want** to be), what percent of your goal would you rate yourself **currently**?
(0 to 100%) _____ %

Patient Name: _____ Date of Birth: _____
Initial Evaluation Date: _____/_____/_____

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

We appreciate the confidence you have shown in choosing us to provide for your rehabilitative needs. The services you have elected to participate in imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, RESTORE Physical Therapy will pre-verify your primary insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

The patient/guardian is responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Co-pays are due at the time of service. Your deductible/co-insurance will be billed to you once we have received an "Explanation of Benefits" from your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim; or if you or your physician elects to continue therapy past your approved period, you will be responsible for your balance in full.

Balances older than 60 days will accrue interest at a rate of 3% per month. There is a $25.00 fee for returned checks. Collection and billing fees will be charged to any account billed multiple times.

I have read the above policy regarding financial responsibility to RESTORE Physical Therapy, L.L.C. for providing rehabilitative services to me, or the above named patient. I authorize my insurer to pay RESTORE Physical Therapy, L.L.C. the full and entire amount of the bill incurred by the above named patient; or, if applicable, any amount due after payment has been made by the insurance carrier.

PATIENT/GUATANTOR SIGNATURE: _____ DATE: _____

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize RESTORE Physical Therapy, L.L.C. through its appropriate personnel, to perform or have upon the above named patient or me, appropriate assessment and treatment procedures.

I further authorize RESTORE Physical Therapy, L.L.C. to release to appropriate agencies, any information acquired in the course of the above named patient's examination and treatment for treatment and billing purposes.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE:_____

(IF GUARANTOR IS NOT THE PATIENT)

HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the agencies HIPPA Notice of Privacy Practices. The notice provides, in detail, the uses and disclosures of my protected health information that may be made by RESTORE Physical Therapy, my rights as the patient and RESTORE's legal duty with respect to my protected health information. This notice is available for further review on our website at: http://www.restore-rehab.com/forms/hippa_notice_of_privacy_practices.pdf

PATIENT SIGNATURE: _____ DATE: _____

(Or parent if patient is a minor)

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Under HIPPA guidelines we are unable to discuss any part of your care (including appointment times, release of records, billing or your medical condition) to any individual in your family or representative of you without written authorization. Please complete this form if you wish to share your information. *You **do not** need to place physician names here.*

Patient Disclosure Authorization Form

Patient Name: _____ Date of Birth: _____

I authorize disclosure of my protected health information to the individual(s) named below.

Name	Relationship to Patient

Description of information to be released: (please check all that apply)

- ☐ Appointment Times
- ☐ Medical Records Release
- ☐ Billing Information
- ☐ Medical Condition/Prognosis
- ☐ Other (specify):_____

This authorization provides that:

- I may revoke this authorization at any time, provided that my request is made in writing to RESTORE Physical Therapy.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by HIPAA rules and regulations.
- I have a right to access my protected health information that will be used or disclosed.

Signature: _____ Date: _____

Relationship to patient (if signed by guardian/personal representative): _____

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Patient Name: _____ Date of Birth: _____ Date: _____

To ensure insurance reimbursement, we are required to come up with **"Functional" goals** in establishing your **Plan of Care**. To do so, we need to create a clear picture of how you were functioning prior to your present injury, pain or condition (**Prior Level of Function**), where you are now (**Current Limitations**), where you would like to be (**Goals**). Please answer the following questions which are relevant to your functional limitations to the best of your ability. Your therapist will review your answers at the time of your Initial Evaluation. If you have any questions or concerns just leave it blank. Functional goals must be established for all patients utilizing insurance.

(Must check either Yes or No, Do not leave any blank.
Yes is able to fully do with no pain, limitations or restrictions. No is limited to do the activity.)

Prior Level of Function (Prior to your present injury, pain or condition)
Current Level of Function (How you are currently functioning)

Self Care

	PRIOR		CURRENT		GOAL
Hygiene					
Grooming (With Involved Arm)	Yes	No	Yes	No	
Washing Body Parts	☐	☐	☐	☐	
Washing Whole Body	☐	☐	☐	☐	
Drying Oneself	☐	☐	☐	☐	
Caring for Skin	☐	☐	☐	☐	
Caring for Teeth	☐	☐	☐	☐	
Caring for Hair	☐	☐	☐	☐	
Able to Use Blow Dryer	☐	☐	☐	☐	
Caring of Nails (Toe and fingers)	☐	☐	☐	☐	
Dressing					
Putting on Shirts/Pullovers	☐	☐	☐	☐	
Putting on Jackets	☐	☐	☐	☐	
Putting on Pants	☐	☐	☐	☐	
Putting on Socks	☐	☐	☐	☐	
Putting on Shoes	☐	☐	☐	☐	
Removing Shirts/Pullovers	☐	☐	☐	☐	
Removing Jackets	☐	☐	☐	☐	
Removing Pants	☐	☐	☐	☐	
Removing Socks	☐	☐	☐	☐	
Removing Shoes	☐	☐	☐	☐	
Bathing					
Showering	☐	☐	☐	☐	
Bathing	☐	☐	☐	☐	
Toileting					
Self Care	☐	☐	☐	☐	

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Patient Name: _____ Date of Birth: _____ Date: _____

	PRIOR		CURRENT		GOAL
	Yes	No	Yes	No	
Sleep					
Undisturbed Sleep	☐	☐	☐	☐	
Able to Sleep in Bed	☐	☐	☐	☐	
Number of Pillows under your head when you sleep: _____					
IADLs					
Able to Use Phone	☐	☐	☐	☐	
Able to go **S**hopping	☐	☐	☐	☐	
Able to Prepare Food	☐	☐	☐	☐	
Housekeeping	☐	☐	☐	☐	
Vacuuming	☐	☐	☐	☐	
Dusting	☐	☐	☐	☐	
Household Chores					
Cook a Meal	☐	☐	☐	☐	
Laundry	☐	☐	☐	☐	
Drive Community Distances (if appl.)	☐	☐	☐	☐	Time:
Volunteering	☐	☐	☐	☐	
Care giving	☐	☐	☐	☐	

Mobility: Walking and Moving Around:

IADLs					
Shopping	☐	☐	☐	☐	
Use of an Assistive Device	☐	☐	☐	☐	
If Yes:					
Walker	☐	☐	☐	☐	
Straight Cane	☐	☐	☐	☐	
Other: _____	☐	☐	☐	☐	
Walking					
Forward	☐	☐	☐	☐	Distance:
Sideways	☐	☐	☐	☐	
Backwards	☐	☐	☐	☐	
Different Surfaces	☐	☐	☐	☐	
Around Obstacles	☐	☐	☐	☐	
Moving Around					
Climbing	☐	☐	☐	☐	
Running	☐	☐	☐	☐	
Jogging	☐	☐	☐	☐	
Skipping	☐	☐	☐	☐	
Jumping	☐	☐	☐	☐	
Swimming	☐	☐	☐	☐	

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Patient Name: _____ Date of Birth: _____ Date: _____

	PRIOR		CURRENT		GOAL
	Yes	No	Yes	No	
Moving Around Different Surfaces					
Walking Between Rooms	☐	☐	☐	☐	
Stairs	☐	☐	☐	☐	Rail / No Rail
No Use of Rail	☐	☐	☐	☐	
Normal Step over Step Up	☐	☐	☐	☐	Yes / No
Normal Reciprocal Step Down	☐	☐	☐	☐	Yes / No
Inclines and Declines (ramps)	☐	☐	☐	☐	
Community Distances	☐	☐	☐	☐	Distance:
Negotiate Obstacles					
Bumped in Crowded Areas	☐	☐	☐	☐	
Walk on Uneven Terrain	☐	☐	☐	☐	

Changing and Maintaining Body Position:

Maintaining a Body Position					
Remaining Seated (No limitation)	☐	☐	☐	☐	Time:
Remaining Standing (No limitation)	☐	☐	☐	☐	Time:
Squatting (Full)	☐	☐	☐	☐	
Kneeling	☐	☐	☐	☐	
Transfers					
Sit to stand without use of hands	☐	☐	☐	☐	Yes / No
In and out of shower	☐	☐	☐	☐	
In and out of bathtub	☐	☐	☐	☐	

Carrying and Handling Objects:

IADLs					
Ability to Use Telephone	☐	☐	☐	☐	
Shopping	☐	☐	☐	☐	
Able to Prepare Food	☐	☐	☐	☐	
Cutting Food	☐	☐	☐	☐	
Housekeeping	☐	☐	☐	☐	
Laundry	☐	☐	☐	☐	
Hand and Arm Use					
Pulling Objects	☐	☐	☐	☐	
Pushing Objects	☐	☐	☐	☐	
Reaching Fully Overhead	☐	☐	☐	☐	Kitchen Shelf: 3rd / 2nd / 1st
IF NO:					
Limited to Reaching Top of Head	☐	☐	☐	☐	
Limited to Shoulder Height	☐	☐	☐	☐	
Limited to Chest Height	☐	☐	☐	☐	

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Patient Name: _____ Date of Birth: _____ Date: _____

	PRIOR		CURRENT		GOAL
	Yes	No	Yes	No	
Reaching Behind Back Fully	☐	☐	☐	☐	
IF NO:					
Limited Fastening Bra (Females)	☐	☐	☐	☐	
Limited to Lower Back	☐	☐	☐	☐	
Limited with Tucking in Shirts	☐	☐	☐	☐	
Limited Reaching into Back Pocket	☐	☐	☐	☐	
Limited to side of hip	☐	☐	☐	☐	
Turning or twisting hands/arms	☐	☐	☐	☐	
Using Keys (Car/Doors)	☐	☐	☐	☐	
Turning Door Knobs	☐	☐	☐	☐	
Throwing	☐	☐	☐	☐	
Catching	☐	☐	☐	☐	
Fine Use of Hand					
Picking Items Up	☐	☐	☐	☐	
Grasping/gripping	☐	☐	☐	☐	
Releasing Items	☐	☐	☐	☐	
Moving Objects with Legs					
Kicking	☐	☐	☐	☐	
Pushing with Legs	☐	☐	☐	☐	
Work	☐	☐	☐	☐	
Recreation	☐	☐	☐	☐	
Sports	☐	☐	☐	☐	

List Sports/Hobbies: _____

_____