



PATIENT INFORMATION

NAME
ADDRESS
CITY/STATE ZIP
PATIENT'S GENDER [] MALE [] FEMALE
DATE OF BIRTH SSN
CARETAKER/INTERPRETER
REFERRING DOCTOR
DR. PHONE NUMBER
PRIMARY CARE DR.
DR. PHONE NUMBER

Please select 2 preferred contact methods for reminders:

[] HOME PHONE
[] CELL PHONE
[] TEXT MESSAGE
[] EMAIL

EMERG. CONTACT
RELATION TO YOU PHONE #
BODY PART AFFECTED
HAVE YOU HAD PT THIS YEAR?
DATE OF ONSET/INJURY
IS INJURY FROM: [] AUTO [] WORK [] OTHER

HOW DID YOU HEAR ABOUT US?

HEALTHCARE PROVIDER FAMILY / FRIEND INTERNET SEARCH
SOCIAL MEDIA EVENT OTHER

INSURANCE POLICY INFORMATION

PRIMARY HEALTH INSURANCE

INSURANCE COMPANY
IDENTIFICATION NUMBER
GROUP NUMBER
PRIMARY INSURED NAME
RELATION TO PATIENT
PRIMARY INSURED DATE OF BIRTH
[] Insurance Card Provided?

SECONDARY HEALTH INSURANCE

INSURANCE COMPANY
IDENTIFICATION NUMBER
GROUP NUMBER
PRIMARY INSURED NAME
RELATION TO PATIENT
PRIMARY INSURED DATE OF BIRTH
[] Insurance Card Provided?

————— If treatment relates to an Auto or Work related injury, please provide the information below. —————

YOUR AUTO/L&I INFORMATION

INSURANCE COMPANY
CLAIM NUMBER
ADDRESS
CITY/STATE ZIP
ADJUSTER'S NAME
PHONE NUMBER

ATTORNEY

NAME
FIRM
PHONE NUMBER

PATIENT AGREEMENT-PLEASE READ CAREFULLY

I authorize treatment of the patient named above and agree to pay all charges for such treatment that may or may not be covered by my insurance. I also authorize the provider to release any information to referring/consulting physicians or other health care providers that may be necessary to facilitate care. I hereby authorize my insurance benefits to be paid directly to Manual Therapy International (dba MTI Physical Therapy). I certify that a copy of this agreement shall be valid as the original.

[Signature box]

[Date box]

Patient or Legal Guardian Signature

Date

FINANCIAL POLICY

PLEASE READ CAREFULLY AND SIGN

It is your responsibility to know the limitations and restrictions of your insurance company regarding physical therapy. By signing below you hereby authorize your insurance benefits to be paid directly to MTI Physical Therapy. You are responsible for paying your balance regardless of your insurance company's payments. **Copays are due at the time of service.** If your insurance company does not cover physical therapy and you choose to pay out of pocket for treatment, your balance is due at the time of your appointment.

In the event it should become necessary to forward your unpaid balance to a collection agency, you agree to pay interest and collection fees. If legal action is taken against your account, you agree to pay all reasonable attorney fees, filing fees and any other costs associated with this action. Checks returned without sufficient funds will be charged a \$35.00 fee.

Signature of Patient or Legal Guardian

Date

Missed Appointments & Cancellations: appointments not kept or cancelled without 24 hours notice prior to the scheduled appointment time will be charged a **\$95.00** cancellation fee. These charges cannot be billed to your insurance company and will be your responsibility. Missed appointment fees must be paid at the next scheduled appointment. If you miss 3 appointments without proper notice, all future appointments will be cancelled.

Signature of Patient or Legal Guardian

Date

WASHINGTON ATHLETIC CLUB MEMBERS: The services provided under this agreement are being provided solely by Manual Therapy International (dba MTI Physical Therapy) and not the Washington Athletic Club (WAC). The provider is an independant contractor. The WAC is not responsible for costs incurred for physical therapy treatment.

PRIVACY POLICIES STATEMENT/HIPAA

You have the opportunity to review and question our privacy policies statement at your request. This statement outlines our policies that protect your privacy. We will release your personal health information for billing purposes to be reimbursed for services rendered or to facilitate your care with another of your health care providers. You may request (in writing) to prevent us from doing so without penalty or cessation of your care. If you exercise this right, you will be responsible for your balance and it will be your responsibility to submit claims to your insurance carrier for reimbursement.

Signature of Patient or Legal Guardian

Date



PATIENT HEALTH QUESTIONNAIRE

NAME WEIGHT HEIGHT AGE SEX

Check all boxes that apply.

Have you or any immediate family member ever been told you have:

Table with 3 columns: Condition, You, Family. Rows include Cancer, High Blood Pressure, Diabetes, Heart Disease, Angina/Chest Pain, Stroke, and Arthritis.

Do you have a history of:

- Shortness of Breath, Allergies, Asthma, Bronchitis, Kidney Disease/Stones, Polio, Emphysema, Anemia, Rheumatic Fever, Ulcers

Check all boxes that apply.

With current problem do you experience:

- Nausea/Vomiting, Fever/Chills/Sweats, Unexplained Weight Change, Numbness or Tingling, Bowel or Bladder Changes, Dizziness, Night Pain, Headaches, Muscular Weakness, Surgery

For this problem have you received treatment from:

- Orthopedist, Physiatrist, Neurosurgeon, Chiropractor, Massage Therapist, Osteopath, Acupuncturist, Psychologist, Other Physical Therapist, Other

Have you had any recent illness, to include upper respiratory infections (flu) or urinary tract infections?

- No, Yes, Describe:

Do you use caffeine?

- No, Yes # of cups per day?

How often do you feel stress is a significant factor in your life?

- Never, Seldom, Regularly, Always

List regular exercise/activity:

.....
.....
.....
.....

Date of last complete physical examination?

Do you smoke?

- No, Yes How many packs?..... For how long?

Other comments:

.....
.....
.....
.....

Do you drink alcohol?

- No, Yes # of drinks per week?



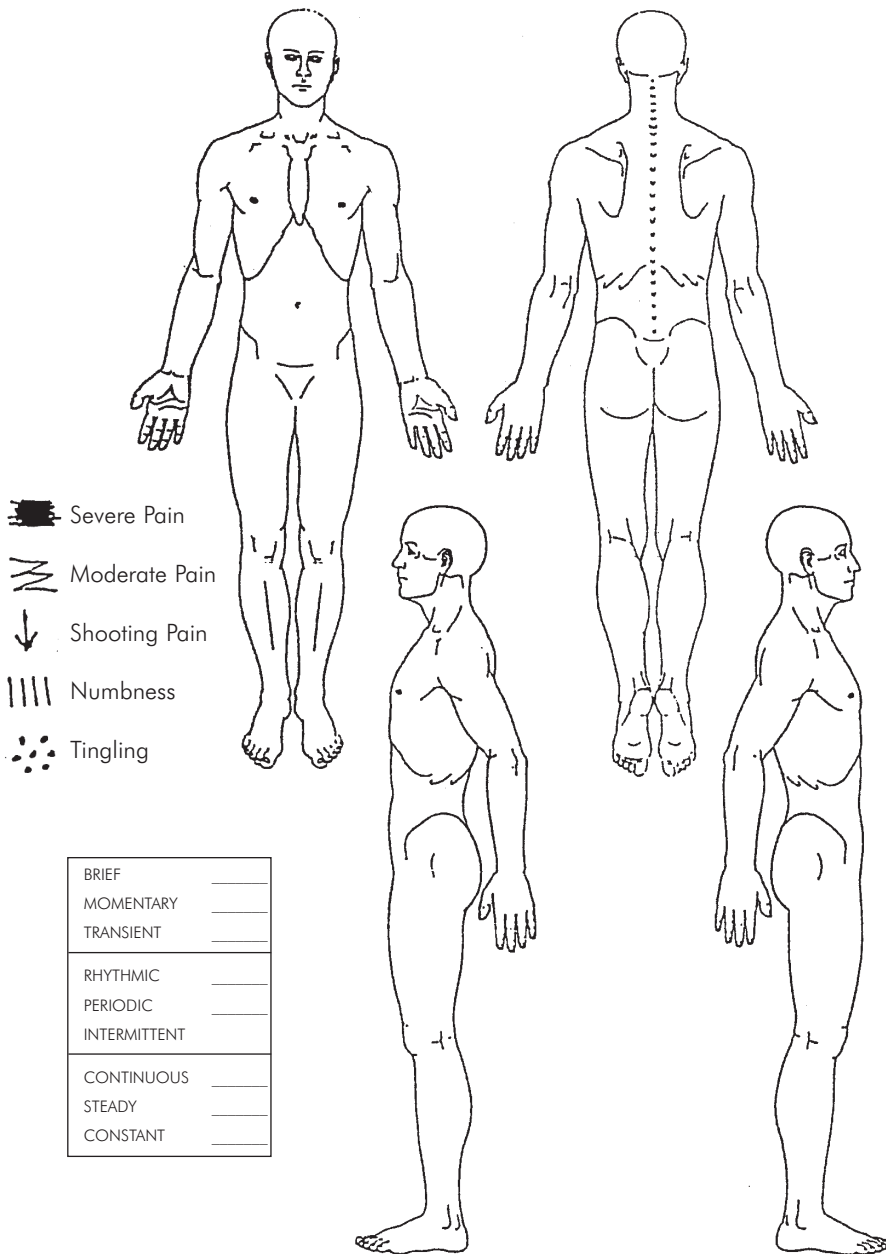
McGILL PAIN QUESTIONNAIRE

Patient Name

Date

DIRECTIONS: There are many words that describe pain. Some of these words are grouped below. IF YOU ARE EXPERIENCING ANY PAIN, check (✓) any words that describe your pain.

1. Flickering _____ Quivering _____ Pulsing _____ Throbbing _____ Beating _____ Pounding _____	13. Fearful _____ Frightful _____ Terrifying _____
2. Jumping _____ Flashing _____ Shooting _____	14. Punishing _____ Grueling _____ Cruel _____ Vicious _____ Killing _____
3. Pricking _____ Boring _____ Drilling _____ Stabbing _____ Lancinating _____	15. Wretched _____ Blinding _____
4. Sharp _____ Cutting _____ Lacerating _____	16. Annoying _____ Troublesome _____ Miserable _____ Intense _____ Unbearable _____
5. Pinching _____ Pressings _____ Gnawing _____ Cramping _____ Crushing _____	17. Spreading _____ Radiating _____ Penetrating _____ Piercing _____
6. Tugging _____ Pulling _____ Wrenching _____	18. Tight _____ Numb _____ Drawing _____ Squeezing _____ Tearing _____
7. Hot _____ Burning _____ Scalding _____ Searing _____	19. Cool _____ Cold _____ Freezing _____
8. Tingling _____ Itchy _____ Smarting _____ Stinging _____	20. Nagging _____ Nauseating _____ Agonizing _____ Dreadful _____ Torturing _____
9. Dull _____ Sore _____ Hurting _____ Aching _____ Heavy _____	ACCOMPANYING SYMPTOMS: Nausea _____ Headache _____ Dizziness _____ Constipation _____ Diarrhea _____
10. Tender _____ Taut _____ Rasping _____ Splitting _____	ACTIVITY: Good _____ Some _____ Little _____ None _____
11. Tiring _____ Exhausting _____	SLEEP: Good _____ Fitful _____ Can't sleep _____
12. Sickening _____ Suffocating _____	FOOD INTAKE: Good _____ Some _____ Little _____ None _____



BRIEF	_____
MOMENTARY	_____
TRANSIENT	_____
RHYTHMIC	_____
PERIODIC	_____
INTERMITTENT	_____
CONTINUOUS	_____
STEADY	_____
CONSTANT	_____

No Pain _____ Worst Possible Pain

SLEEP: Good _____ Fitful _____ Can't sleep _____	FOOD INTAKE: Good _____ Some _____ Little _____ None _____	COMMENTS:
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