mti physical therapy
PROVIDING ONE-TO-ONE CARE

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.

Patient or Legal Guardian Signature

Date

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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*

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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:

	You	Family
Cancer	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Angina/Chest Pain	☐	☐
Stroke	☐	☐
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: .....

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

☐ Never ☐ Seldom ☐ Regularly ☐ Always

Date of last complete physical examination? .....

Do you smoke?

☐ No ☐ Yes How many packs? .....
For how long? .....

Do you drink alcohol?

☐ No ☐ Yes # of drinks per week? .....

Do you use caffeine?

☐ No ☐ Yes # of cups per day? .....

List regular exercise/activity:

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

Other comments:

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

[see next page]

Name: _____ Date: _____

Modified STarT Back Screening Tool (mSBT)

Thinking about the **last 2 weeks** tick your response to the following questions:	Disagree 0	Agree 1
1. My current pain has spread to other body regions at some time in the last 2 weeks	☐	☐
2. I have had pain in other body regions other than my primary current pain	☐	☐
3. I have only walked short distances because of my current pain	☐	☐
4. In the last 2 weeks, I have dressed more slowly than usual because of current pain	☐	☐
5. I can't do all the things normal people do because it's too easy for me to get injured	☐	☐
6. I worry too much over something that really doesn't matter	☐	☐
7. I feel terrible, and I think it's never going to get any better	☐	☐
8. Little interest or pleasure in doing things	☐	☐

9. Overall, how bothersome has your current pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ Sub Score (Q5-9):_____

Pain/Symptom Ratings and Descriptions

Please Rate your primary pain [P1]

0 = None 5 = Moderate 10 = Extreme

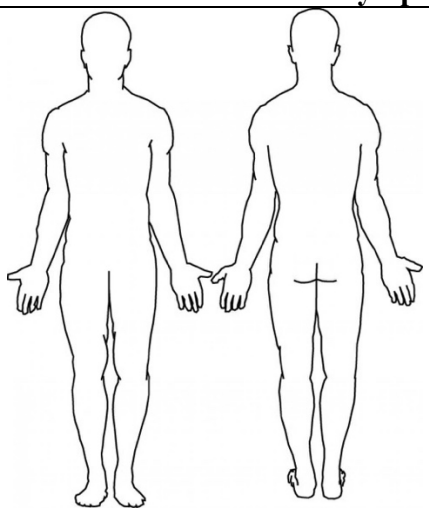
	NT	0	1	2	3	4	5	6	7	8	9	10
At worst:	○	○	○	○	○	○	○	○	○	○	○	○
Current:	○	○	○	○	○	○	○	○	○	○	○	○
At best:	○	○	○	○	○	○	○	○	○	○	○	○

Please Rate if you have a 2nd Region of Pain [P2]

0 = None 5 = Moderate 10 = Extreme

	NT	0	1	2	3	4	5	6	7	8	9	10
At worst:	○	○	○	○	○	○	○	○	○	○	○	○
Current:	○	○	○	○	○	○	○	○	○	○	○	○
At best:	○	○	○	○	○	○	○	○	○	○	○	○

Please Draw the Location of Symptoms



Medication List

MTI Physical Therapy

Patient Name: _____ Therapist: _____

Date of Birth: _____ Date: _____

Allergies:

MEDICATION brand, generic name, dose	Dose	When Taken	STARTED taking on:	REASON FOR TAKING	WHO Told Me To Take This ?