FOOTHILLS PHYSICAL THERAPY

PATIENT HISTORY

Date: _____

Name: _____ DOB: _____

Address: _____ SS#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer _____ Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Have you previously had physical therapy? Yes No When? _____

Are you currently receiving any type of VNA Services? Yes No

Was it for the same problem that you are currently seeking treatment? Yes No

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Primary Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

How did you hear about us? _____

PLEASE COMPLETE: Name of Insurance to Bill: _____

Address: _____ City: _____ State: _____ Zip: _____

ID/Claim#: _____ Group #: _____

Health Insurance Subscriber: (circle one) Self Spouse Parent

If other than self: Name: _____ DOB: _____

If Injury is related to work or an auto accident - DATE OF INJURY _____

PLEASE CIRCLE if applicable: AUTO: YES/NO State of accident _____ **WORKERS COMP:** YES/NO

Adjuster: _____ Phone #: _____

PRIVACY NOTICE

We here at Foothills Physical Therapy feel that your privacy should be protected. In the course of your treatment, we collect person information about you that is necessary to treating you. As our valued patient, we treat this information as confidential and recognize the importance of protecting it. A copy of our complete HIPPA Notice of Privacy Practices is available upon request. By signing below, I acknowledge that I have been permitted to access and/or have a copy of this information.

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Foothills Physical Therapy.

Signature of Patient or Guardian _____ Date _____

28 Commercial Street, Suite 4, Concord NH 03301 Phone (603)-225-5132 Fax (603)-225-6061

www.foothillsphysicaltherapy.com

FOOTHILLS PHYSICAL THERAPY

PATIENT HISTORY

Date: _____

PAYMENT POLICY

Financial Arrangements/Insurance:

Foothills Physical Therapy has agreed to submit claims to your primary and secondary insurances. Ultimately, you are responsible for any co-insurance, co-payment, deductible, and reduction of benefits or denial for pre-existing conditions. Since each patient's insurance policy is different, you must notify us immediately if your insurance requires pre-authorization.

Not all insurances cover supplies that your therapist may determine as necessary for your treatment. Although we will submit these charges to your insurance company, their coverage is not a guarantee and payment is required at time of purchase.

Payment is expected at time of service. We accept cash, check, MasterCard, or Visa.

In special circumstances if the above terms cannot be met, we can discuss your individual needs and set up a mutually agreeable payment plan.

MEDICARE: Medicare will cover 80% of the approved charges for therapy services after a calendar year deductible. **Medicare recommends that the patient see their physician to begin treatment.**

Appointments:

In the event that an appointment needs to be cancelled or changed, we must have 24-hours' notice. This allows us to accommodate other patients who are waiting for appointment times. In case of broken appointments in which adequate notice was not given, you will be charged a fee of **$25.00**. After two instances of broken appointments or short-notice cancellations, we have the discretion to dismiss you from our practice. An answering machine is available during off hours.

If at any time you have questions or concerns, please do not hesitate to speak with the Front Desk.

_____ _____ _____

(Signature) (Print name) (Date)

28 Commercial Street, Concord, NH 03301
603-225-5132 (answering machine available during off hours)
www.foothillsphysicaltherapy.com

Foothills Physical Therapy
TMJ Questionnaire

Date: _____

Name: _____ **Age:** _____ **Occupation:** _____

1. Patient's complaint:

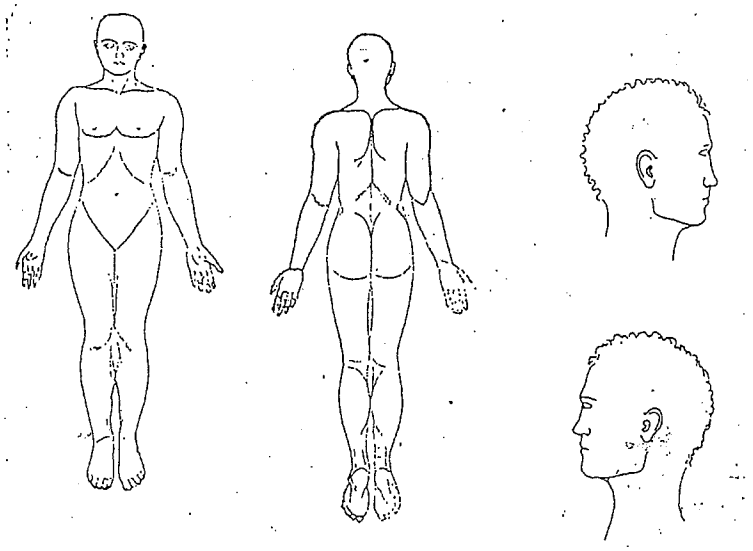
2. How sustained:

   Past Trauma -

3. What makes your pain worse? Chewing _____ Yawning _____ Stress _____
4. What, if anything, eases your pain?
5. Does your jaw make a noise on movement? Yes_____ No_____
6. Has your Jaw ever locked? Open_____ Closed_____ Date: _____
7. Do you clench or grind your teeth? Yes_____ No_____
8. Is your face and mouth tired in the morning? Yes_____ No_____
9. Are your teeth sore or sensitive? Yes_____ No_____
10. Is it difficult to swallow? Yes_____ No_____
11. Do you have a tendency to bite your cheeks, lips or tongue while chewing or swallowing? Yes_____ No_____
12. Do you have any problems or pain with your ears? Left Right
13. Do you have pain in or around the eyes? Yes_____ No_____
14. Do you have headaches? (see chart) Yes_____ No_____
15. Do you have any numbness? (see chart) Yes_____ No_____
16. Have you had any surgery? Yes_____ No_____
17. Have you had any major dental work done? Yes_____ No_____
18. Do you feel tired when you get up in the morning? Yes_____ No_____
19. Who else has seen you for this problem and what did they do?
20. Do you feel your jaw should be in a different position? If so, briefly describe :
21. Do you feel your posture has changed? If yes, explain how :
22. Is your pain constant _____ intermittent_____?
23. Are you under a lot of stress or tension? Yes_____ No_____
24. On a scale of 1-10 (10 being the worst, and 0 being no pain) how would you score your pain now? _____

PLEASE COMPLETE OTHER SIDE

Please indicate on the drawing <u>all</u> your areas of discomfort.



Have you or any immediate family member ever been diagnosed with: (Please Circle Yes or No, Self and/or Family)

Cancer	yes	no	self	family	Angina/Chest Pain	yes	no	self	family
High Blood Pressure	yes	no	self	family	Stroke	yes	no	self	family
Diabetes	yes	no	self	family	Arthritis	yes	no	self	family
Heart Disease	yes	no	self	family					

Have you had or recently experienced:

Nausea/Vomiting	yes	no	Fever/Chills/Sweats	yes	no
Numbness/tingling	yes	no	Muscular Weakness	yes	no
Fainting Spells	yes	no	Dizziness	yes	no
Night Pain	yes	no	Headaches	yes	no
Surgery	yes	no	Hospitalization	yes	no
Unexplained weight loss	yes	no	Bowel/bladder changes	yes	no

If yes, please explain:_____

_____

Do you have a history of:

Shortness of Breath	yes	no	Allergies	yes	no
Asthma	yes	no	Bronchitis	yes	no
Kidney Disease/stone	yes	no	Polio	yes	no
Emphysema	yes	no	Anemia	yes	no
Rheumatic Fever	yes	no	Ulcers	yes	no
Seizures	yes	no	Other illnesses	yes	no

Have you had any recent illnesses, including upper respiratory infections, flu, or urinary tract Infections? yes no

Do you smoke? yes no If yes, how many packs per day? _____ For how many years? _____

Do you use alcohol? yes no If yes, how many drinks per day? _____ How many per week? _____

Do you consume caffeine? yes no Of yes, how many cups per day? _____

Do you currently use or have you ever used a C-PAP Machine? Yes No

Do you have any allergies to latex? Yes No

Please list your medications: _____

What do you want Physical Therapy to do for you?

_____