Client Medical History

Name: _____ Date of Birth:_____ Today's date: _____
Referring physician: _____ Date of injury or onset: _____
Date of 1st doctor visit for this injury: _____ Date of next doctor's visit: _____
Is an attorney involved in this case? ❑ Yes ❑ No

Have you had any of the following medical or rehab services for this injury/episode? Please check if "yes":

❑ General practitioner	❑ Emergency Room care	❑ X-rays
❑ Chiropractic	❑ Neurologist	❑ CT scan
❑ Massage therapy	❑ Orthopedist	❑ MRI
❑ Occupational therapy	❑ Podiatrist	❑ EMG/NCV
❑ Physical therapy	❑ Acupuncture	❑ Myelogram

❑ Other: _____

Are you currently taking any prescription or non-prescription medication? ❑ Yes ❑ No

Type:	Dosage:	Frequency:

(Add additional list if needed)

Do you have a pacemaker? ❑ Yes ❑ No **Are you pregnant?** ❑ Yes ❑ No
Severe allergies (i.e. latex, oils, perfumes, peanuts, etc.) _____
Do you currently have cancer, or have you had cancer within the past 5 years? ❑ Yes ❑ No
Have you had any falls in the last year? ❑ Yes ❑ No **If yes, how many?** _____
During the past month, have you often been bothered by:
- feeling down, depressed or hopeless? ❑ Yes ❑ No
- little interest or pleasure in doing things? ❑ Yes ❑ No

Do you now have, or have you ever had, any of the following? Please check if "yes":

❑ Shortness of breath	❑ Asthma, bronchitis, or emphysema
❑ Heart disease or angina (chest pain)	❑ Vision or hearing problems
❑ Heart attack or cardiac surgery	❑ Numbness or tingling
❑ Congestive heart disease	❑ Dizziness or fainting
❑ High blood pressure	❑ Bowel or bladder problems
❑ Stroke or TIA	❑ Weakness
❑ Blood clot or embolism	❑ Recent, unexplained weight loss or energy loss
❑ Epilepsy or other seizures	❑ Hernia
❑ Thyroid disease or goiter	❑ Varicose veins
❑ Anemia	❑ Severe or frequent headaches
❑ Infectious disease	❑ Pins or metal implants
❑ Diabetes	❑ Joint replacement surgery
❑ Chemotherapy and/or radiation	❑ Neck injury or surgery
❑ Arthritis	❑ Shoulder injury or surgery
❑ Osteoporosis	❑ Elbow/hand injury or surgery
❑ Gout	❑ Back injury or surgery
❑ Sleeping difficulty	❑ Knee injury or surgery
❑ Pain at night or night sweats	❑ Leg/ankle/foot injury or surgery
❑ Emotional or psychological concerns	❑ Other injury or surgery _____

Do you use: ❑ tobacco ❑ alcohol ❑ marijuana (medical or recreational) ❑ other or illicit drugs

(Please continue to back side)

Physical Therapy Initial Evaluation

Pre-Exam Questionnaire

1. Check ALL that apply to your current symptoms:

- ❑ Work related injury
- ❑ Motor vehicle accident
- ❑ Athletic or recreational injury
- ❑ Recurrence of previous injury
- ❑ Other _____
- ❑ Injury related to lifting
- ❑ Injury related to falling
- ❑ Chronic or long-term issue
- ❑ Cause unknown

2. Are you presently working?

❑ Working full duty ❑ Working modified or light duty ❑ I am not working

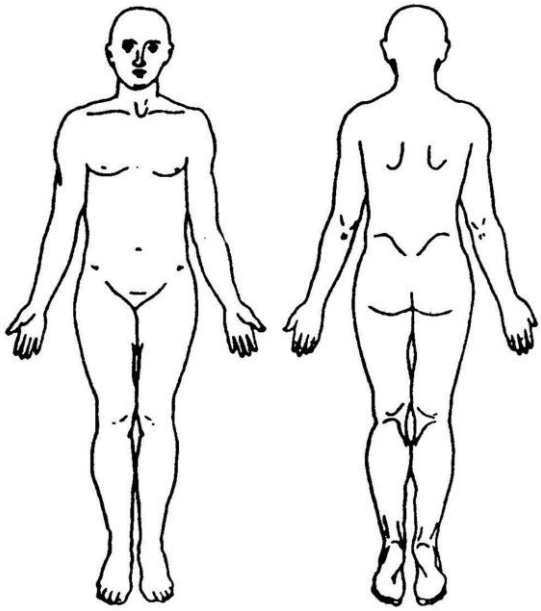
If working, date returned to work: _____

If not working, last date worked due to injury: _____

What is your occupation? _____

3. What is the location of your current pain or problem?

Please mark the picture at right with an "X" where you feel pain. →



4. Have you ever had this pain or problem before? ❑ Yes ❑ No

5. Is your pain or problem…?

❑ getting worse ❑ getting better ❑ staying the same

6. Is your pain or problem…?

❑ constant ❑ frequent ❑ occasional ❑ infrequent

7. On the scale below, please circle your worst pain level in the past few days:

mild *moderate* *severe*

0…….1…….2…….3…….4…….5…….6…….7…….8…….9…….10

8. Are any of your usual activities affected? ❑ Yes ❑ No

If yes, please specify: _____

9. Are you aware of your diagnosis & prognosis as explained by your doctor? ❑ Yes ❑ No

10. Based on your awareness, what are your rehabilitation expectations and goals while in physical therapy?

_____

_____

_____

_____

The above information is accurate to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

For Office Use Only:

Height: Weight:

Oasis Physical Therapy – Patient Registration Form

Patient Demographic Information

Last Name: _____ First Name: _____ Middle Initial: _____

SSN: _____ Cell Ph: _____ Alt Ph: _____ Status: Single/Married/Widowed

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

Gender: Male / Female Date of Birth:_____ Email Address: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Employment Information

Employer Name: _____ Phone Number: _____

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

Work Injury / Motor Vehicle Accident

Claim Manager: _____ Claim Manager Phone: _____

Are you represented by an Attorney Yes / No Attorney Name & Phone: _____

○ Work Related Injury: Yes / No Date of Injury: _____ Claim #: _____ State: ___

○ Motor Vehicle Accident: Yes / No Date of Accident:_____ Claim #: _____ State: ___

Commercial Insurance

Primary Insurance: _____ ID/Policy #: _____ Group #: _____

Subscriber Name:_____ Social Security #: _____ DOB: _____

Secondary Insurance: _____ ID/Policy #: _____ Group #: _____

Subscriber Name:_____ Social Security #: _____ DOB: _____

Responsible Party Information (Required if Patient is a Minor)

Last Name: _____ First Name: _____ Middle Initial: _____

SSN: _____ Date of Birth_____ Gender: Male / Female

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

Home Ph: _____ Cell Ph: _____ Relationship to Patient: Self / Spouse / Child / Other

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I authorize Oasis Physical Therapy to render physical therapy services to myself or person to whom I am legal guardian. I understand I am financially responsible for any balance. I also authorize Oasis Physical Therapy or my insurance company to release any information required to process my claims. I authorize Oasis Physical Therapy or any collection company to contact me by my cellular telephone for billing activities or payment arrangements. I have read and understand all of the above information. The information provided is true and correct to the best of my knowledge.

Signed for myself and dependents: _____ Date: _____

Notification of Policies

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

Acknowledgment of Receipt of Privacy Practices:

I have received a copy of Oasis Physical Therapy's notice of Privacy Practices. I understand that I have the right to refuse to sign the acknowledgment if I so choose.

Oasis Physical Therapy can discuss all aspects of my care with:

Contact Name:_____ Relationship: _____
Contact Name:_____ Relationship: _____

Initial_____

Assignment and instructions for direct payment to Oasis Physical Therapy:

I hereby instruct _____ insurance company to pay: **Oasis Physical Therapy, PLLC at 6825 Burden Blvd, Ste D, Pasco, WA 99301.** If my policy prohibits direct payment to provider, then I hereby instruct and direct you to make out the check to me and mail it to the address above. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to Oasis Physical Therapy, and I have agreed to pay any balance of said professional charges over and above the insurance payment. I also authorize any release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

No Show & Cancellation Policy:

Each time an appointment is missed without proper notice, another patient is prevented from receiving the care they need. It is for this reason that we require notification of cancellation 24 hours before all scheduled appointments.

Oasis Physical Therapy reserves the right to charge a fee of $40.00 for missed appointments without prior notice of cancellation ("no shows"). No show fees are not covered by your insurance plan. No Show fees must be paid prior to your next scheduled appointment.

Appointments canceled with less than 24 hours advance notice will not be charged a fee, however any patient with an excessive number of late-notice cancellations may lose the privilege to reserve their appointments in advance.

Thank you for your cooperation. This allows us to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice, understand the importance of attending scheduled appointments, and agree to comply with this policy.

Patient Signature: _____ Date:_____

Our Commitment to You:

At Oasis, our goal is to provide the highest quality physical therapy and world-class customer service. We know you have many choices when it comes to your health, and we're honored you chose us to help you achieve your goals. As a thank you, below are our commitments to you:

- We respect your schedule. We will begin your appointments on time, every time.
- We will advocate for your care and navigate your insurance requirements. We'll worry about the red tape so that you can focus on your treatment.
- We care about your comfort. We promise to protect your privacy and modesty during your visit.
- We will provide hands-on care and individually designed treatment. We'll build a plan that's specific to your needs.
- We commit to making it right. If at any time, you feel that we're not meeting your expectations, or keeping our commitments to you, we want to know! You can share your thoughts with any member of our team directly, or by sending your comments to *info@oasisphysicaltherapy.com* **Your feedback makes us better!**