Patient's name:_____Email Address:_____

Do you wish to receive emails with special offers/newsletters? Yes No

I acknowledge I have read and understand this office's Notice of Privacy Practices. (A copy can be furnished to you at your request)

List your home number: _____ ☐ Yes, leave a message ☐ No, do not leave a message
List your work number: _____ ☐ Yes, leave a message ☐ No, do not leave a message
List your cell number: _____ ☐ Yes, leave a message ☐ No, do not leave a message

Please list any people who are allowed to receive protected healthcare information: _____
_____

Consent to Physical Therapy

1. I hereby authorize the release of medical information necessary to process my insurance. I also request payment of government benefits either to myself or to Comprehensive Therapy Services. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. If this authorization is given in connection with a claim for disability or life insurance benefits, I understand that it is valid for the duration of the claim. I agree that a photocopy of this authorization is as valid as the original.

2. I authorize payment and assignment of my health insurance benefits directly to Comprehensive Therapy Services, Inc. I fully understand that I am financially responsible for any services not covered by this authorization.

3. I have presented myself to this facility for physical therapy treatments and consent to diagnostic procedures and care provided by my attending physical therapist. Your comfort is our priority. If you would like more privacy than our gym offers, treatment will be rendered in a private room. You may request a chaperone for your private treatment session as needed.

4. I realize I have the right to refuse any drugs, treatments, and procedures to the extent permitted by law. I acknowledge that medicine is not an exact science. No guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational administrative, and/or facility approved purposes when my personal identity will not be revealed.

5. **NOTE TO WORKERS COMP** I hereby authorize my rehab consultant to receive my records related to my work injury. This information may be faxed or mailed.

6. I understand, if I do not attend physical therapy for four weeks or miss three consecutive appointments that I am subject to discharge, or I do not inform my physical therapist of such absences. Once I have been discharged, I understand that I will need a new physician's order/referral for any further therapy and will be receiving a new evaluation. This is in compliance with the California State Law.

7. "LATE FEES" Patient balances due are to be paid once the insurance has processed and paid or denied your claims. If not paid timely, a $5.00 late fee could be incurred per billing cycle. Co-pays are due at the time of service and are also subject to the late fee.

8. Children must be supervised. For safety reasons, children are not allowed in the therapy area.

9. Durable medical equipment may be suggested by your physical therapist. Please be advised CTS is not contracted to bill Insurance for DME, therefore you will be responsible for payment.

10. I agree that in the event of non-payment of any patient balance due, I will bear all costs incurred for collection and/or court fees/legal fees required to satisfy the debt owed, should such court action be required.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD HAVE BEEN FULLY ANSWERED TO MY SATISFACITON.

_____ _____

SIGNATURE OF PATIENT (if the patient is a minor, under 18 yrs of age, parent must sign) **DATE**

CTS Attendance Policy

Let's work together to provide you the best possible care...the care you deserve!

We're glad you have chosen us to provide your medical care! We value your health and patronage. At CTS, our goal is to provide high quality individualized medical care in a timely manner. As a patient of CTS, your concession with our Attendance Policy enables us to better utilize available appointments for our patients in need of medical care and to increase the efficiency of our practice. Thank you for your compliance!

CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of other patients, please be courteous and call CTS promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another patient the possibility to have access to timely medical care.

HOW TO CANCEL YOUR APPOINTMENTS

To cancel appointments, please call (858) 457-8419. If you do not reach a patient coordinator, you may leave a detailed message on the voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call as soon as possible and give you the next available appointment time.

LATE CANCELLATIONS AND NOW SHOWS

A Late Cancellation is considered when a patient fails to cancel their scheduled appointment with a 24 hour advanced notice. A "No Show" occurs when a patient misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "No Show." This includes arriving 15 minutes or later after your scheduled appointment time.

CTS MISSED APPOINTMENT POLICY

At the first occurrence of a No Show, Late Cancellation, or cancellation without reasonable excuse there will be no charge to the patient; however, CTS may send a Courtesy Reminder for the patient to review our Attendance Policy. The second occurrence will result in a Missed Appointment Fee of $50 billed to the patient's account. (This charge is not covered by insurance). The third occurrence will result in a Missed Appointment Fee of $50 billed to the patient's account and may result in discharge from the practice accompanied by a discharge report being sent to the patient's referring physician.

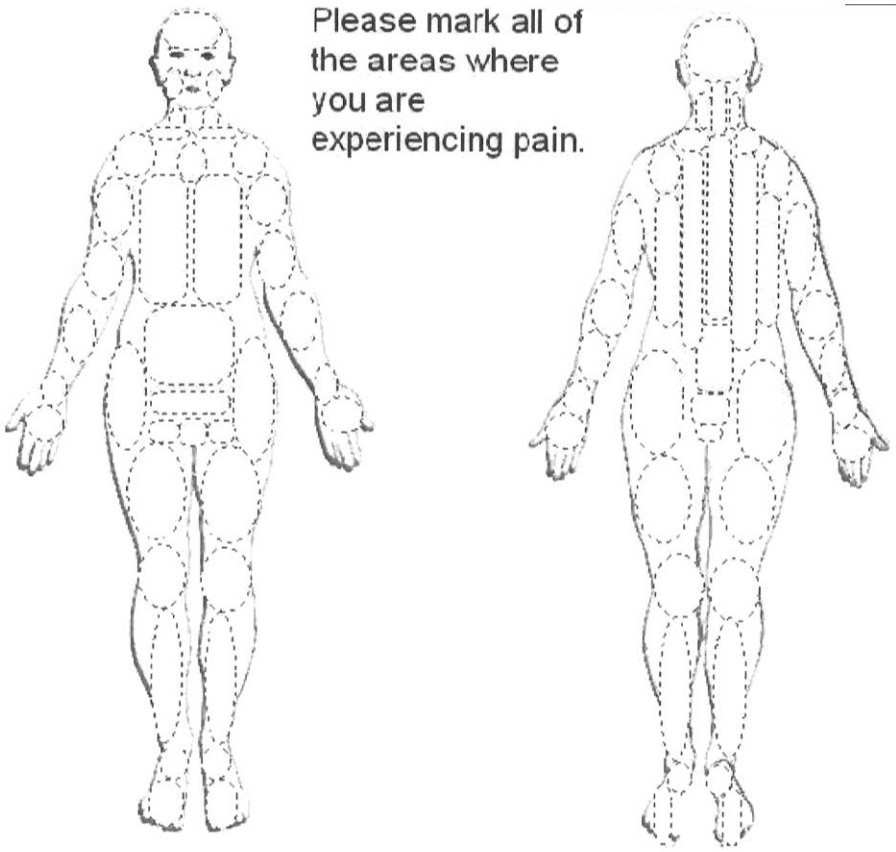
APPOINTMENT REMINDERS

Our scheduling software enables appointment reminders either via text or email. Call our front desk at (858) 457-8419, ext. 1 to set this up if you have not already. Malfunction of appointment reminders is not an excuse for a missed appointment and will still incur a No Show Fee.

PATIENT SIGNATURE: _____

DATE: _____

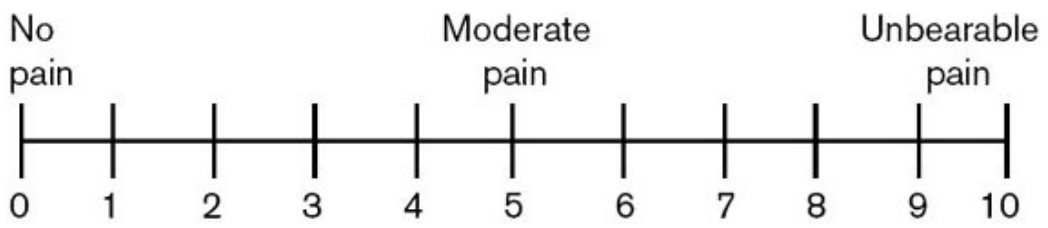
56. PQRS Measure 131, Pain Assessment



Please select all that describes your pain and circle the intensity for each one selected:

Throbbing	Mild	Moderate	Severe
Shooting	Mild	Moderate	Severe
Stabbing	Mild	Moderate	Severe
Sharp	Mild	Moderate	Severe
Cramping	Mild	Moderate	Severe
Gnawing	Mild	Moderate	Severe
Hot / Burning	Mild	Moderate	Severe
Aching	Mild	Moderate	Severe
Heavy	Mild	Moderate	Severe
Tender	Mild	Moderate	Severe
Splitting	Mild	Moderate	Severe
Tiring / Exhausting	Mild	Moderate	Severe
Sickening	Mild	Moderate	Severe
Fearful	Mild	Moderate	Severe
Punishing / Cruel	Mild	Moderate	Severe

Please mark your current pain level on the scale below



Current Condition/Chief Complaint

1. Describe the problem(s) for which you seek physical therapy:

_____
_____
_____
_____
_____
_____
_____

2. When did the problem start?
Date: _____

3. How did the problem start?

_____
_____
_____
_____

4. Have your symptoms changed since they started?
___ No, stayed the same
___ Yes, gotten worse
___ Yes, gotten better

5. Other health care providers you are seeing for this problem:
___ None
___ Acupuncturist
___ Chiropractor
___ Primary care physician
___ Massage therapist
___ Podiatrist
___ Specialist physician: _____
___ Other: _____

6. What are your expectations and goals for physical therapy?

_____
_____
_____
_____
_____

7. Has this problem caused any of the following?
___ None
___ Financial problems
___ Family problems
___ Relationship problems
___ Emotional problems

8. Have you ever had the problem(s) before?
___ No
___ Yes – When: _____

If yes:

a. What did you do for the problem?_____

_____
_____

b. Did the problem get better?
___ Yes
___ No
___ Partially

c. How long did the problem last? _____

Functional Status – General

9. Do you have difficulty with any functional activities?
___ No difficulty
___ Getting into or out of bed
___ Moving from bed to chair
___ Walking on level surfaces
___ Walking up or down stairs
___ Walking on ramps
___ Walking on uneven terrain
___ Other: _____

10. Do you have difficulty with self-care activities?
___ No difficulty
___ Bathing
___ Dressing
___ Eating
___ Toileting
___ Other: _____

11. Do you have difficulty with home management activities?
___ No difficulty
___ Household chores
___ Shopping
___ Driving, transportation
___ Taking care of dependents
___ Preparing meals
___ Other: _____

12. Do you have difficulty with community or work activities?
___ No difficulty
___ Work activities
___ School activities
___ Community activities
___ Recreational activities
___ Play activities
___ Other: _____

13. "How would you rate <u>your overall function</u> as a percentage of normal?
(0% to 100% scale;
100% being normal)

_____ %

14. "How would you rate <u>your affected region</u> today as a percentage of normal?
(0% to 100% scale;
100% being normal)

_____ %

Medications

15. Current medications:
(Medicare patients SKIP THIS)
___ None
___ List: _____
_____
_____
_____

16. Non-prescription medications or supplements:
(Medicare patients SKIP THIS)
___ None
___ List: _____
_____
_____

17. Medications previously taken for current condition:
___ None
___ List: _____
_____
_____

Other Clinical Tests

18. Laboratory and diagnostic tests done:
___ None
___ X-ray
___ MRI
___ CT scan
___ Arthroscopy
___ Bone scan
___ Nerve conduction velocity
___ Exercise stress test
___ Urine tests
___ Other: _____

Medical/Surgical History

19. Cardiovascular:
___ None
___ High blood pressure
___ Heart attack
___ Heart disease
___ High cholesterol
___ Pacemaker
___ Stroke
___ Circulation problems
___ Surgery: _____
___ Other: _____

20. Endocrine/metabolic:
___ None
___ Diabetes or high blood sugar
___ Low blood sugar
___ Thyroid problems
___ Other: _____

21. Gastrointestinal:
___ None
___ Constipation
___ Ulcers
___ Stomach problems
___ Surgery: _____
___ Other: _____

22. Genitourinary:
___ None
___ Prostate disease **(males only)**
___ Kidney problems
___ Recurrent urinary tract infections
___ Surgery: _____
___ Other: _____

23. Gynecological **(females only)**:
___ None
___ Endometriosis
___ Painful periods
___ Trying to conceive
___ Surgery: _____
___ Other: _____

24. Integumentary/Skin:
___ None
___ Skin diseases
___ Sensitive to heat
___ Sensitive to cold
___ Surgery: _____
___ Other: _____

25. Musculoskeletal:
___ None
___ Motor vehicle accident
___ Arthritis
___ Broken bones
___ Osteoporosis
___ Hernia
___ Surgery: _____
___ Other: _____

26. Neurological/Brain:
___ None
___ Headaches
___ Dizzy spells
___ Seizures or epilepsy
___ Head injury
___ MS
___ Parkinson disease
___ Other: _____

27. Neuromuscular:
___ None
___ Balance problems
___ Muscular dystrophy
___ Other: _____

28. Obstetrical **(females only)**:
___ None
___ # of pregnancies: _____
___ # of vaginal births: _____
___ # of cesarean births: _____
___ Currently pregnant
___ Date of most recent birth: _____
___ Currently breastfeeding
___ Other: _____

29. Psychological:
___ None
___ Depression
___ Anxiety
___ Other: _____

30. Pulmonary:
___ None
___ Asthma
___ Lung problems
___ Surgery: _____
___ Other: _____

31. Prior hospitalizations and surgeries:
___ None
___ Yes – List: _____
_____
_____
_____

32. Preexisting medical conditions:
___ None
___ Yes – List: _____
_____
_____
_____

33. Other health-related conditions:
___ None
___ Cancer
___ Vision problems
___ Hearing problems
___ Metal implants
___ Other: _____

34. Allergies:
___ None
___ Yes – List: _____
_____
_____

35. Within the past year, have you had any of the following symptoms:
___ None
___ Chest pain
___ Heart palpitations
___ Cough
___ Hoarseness
___ Shortness of breath
___ Dizziness or blackouts
___ Coordination problems
___ Weakness in arms or legs
___ Loss of balance
___ Difficulty walking
___ Joint pain or swelling
___ Pain at night
___ Difficulty sleeping
___ Loss of appetite
___ Nausea or vomiting
___ Difficulty swallowing
___ Bowel problems
___ Unexplained weight loss
___ Unexplained weight gain
___ Urinary problems
___ Fever or chills or sweats
___ Headaches
___ Hearing problems
___ Vision problems

Family History

36. Have any family members had the following conditions?
___ None
___ Heart disease
___ High blood pressure
___ Stroke
___ Diabetes
___ Cancer
___ Psychological conditions
___ Arthritis
___ Osteoporosis
___ Other: _____

General Health Status

37. How would you rate your general health status?
___ Excellent
___ Good
___ Fair
___ Poor

38. Have you had any major life changes in the past year?
___ None
___ New baby
___ Job change
___ Death of a family member
___ Other: _____

Social/Health Habits

39. Do you exercise beyond normal daily activities and chores?
___ No (sedentary)
___ Yes, occasionally
___ Yes, regularly

If yes:

a. How often do you do cardiovascular/aerobic exercise?
Times per week: _____
Exercise type:
_____
_____
_____
_____

b. How often do you do muscle strengthening exercise?
Times per week: _____

c. How often do you do stretching exercise?
Times per week: _____

40. Do you currently drink alcohol?
___ No
___ Yes

If yes:

a. How often do you drink beer, wine, or other alcoholic beverages?
Times per week: _____
Times per month: _____

b. How many drinks do you have on an average day?
_____

41. Have you ever used illegal drugs?
___ No
___ Yes – Explain:
_____

42. Do you currently smoke tobacco?
___ No
___ Yes

If yes:

a. How many cigarettes?
___ 1 pack per week
___ 1/2 pack per day
___ 1 pack per day
___ 2 packs or more per day

b. How many cigars/pipes per day? ___

43. Have you used tobacco in the past?
___ No
___ Yes

If yes:

a. Year you quit smoking:
_____

General Demographics

44. Race (optional):
___ Caucasian
___ American Indian or Alaska Native
___ Asian
___ African-American
___ Native Hawaiian/Pacific Islander
___ Hispanic or Latino
___ Other: _____

45. Ethnicity (optional):
___ Not Hispanic or Latino
___ Hispanic or Latino

46. Primary language:
___ English
___ Chinese
___ Spanish
___ Tagalog
___ Other: _____

47. Highest education level completed:
___ Elementary school
___ Middle school
___ High school
___ Two-year college
___ Four-year college
___ Graduate school

Social History

48. Are there any cultural or religious beliefs/behaviors that might affect your care?
___ No
___ Yes – List: _____

49. With whom do you live?
___ Live alone
___ Spouse
___ Domestic partner
___ Other adult
___ Child(ren)
___ Parent(s)
___ Other: _____

Employment/Work (Job/School/Play)/ Growth and Development

50. Current work status:
___ Working full-time
___ Working part-time
___ Retired
___ Not employed
___ Disabled

51. Occupation:
___ Homemaker
___ Active duty military
___ Full-time student
___ Part-time student
___ Other: _____

52. Did you have typical development as a baby and child?
___ Yes
___ No – Explain: _____

53. Which is your dominant hand?
___ Right ___ Left
___ Ambidextrous

Living Environment

54. Where do you live?
___ Private home
___ Private apartment
___ Rented room
___ Other:
_____

55. Does your home have any of the following?
___ None
___ Stairs (no railing)
___ Stairs (with railing)
___ Ramps
___ Elevator
___ Uneven terrain
___ Assistive devices in the bathroom

56. Does your home have any of the following hazards?
(Medicare patients ONLY)
___ None
___ Clutter where you walk
___ Exposed electrical cords
___ Furniture or other sharp-edged items in the normal pathways through your home
___ Poor lighting
___ Raised doorway thresholds
___ Slippery floors
___ Steps and stairways
___ Throw rugs

57. Do you use any assistive devices or equipment?
___ None
___ Cane
___ Walker or rollator
___ Manual wheelchair
___ Motorized wheelchair
___ Glasses
___ Hearing aids
___ Other: _____

PATIENT SIGNATURE: _____ **DATE:** _____