

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.

PATIENT SIGNATURE: _____

DATE: _____

NEW PATIENT HISTORY

Name: _____

General Demographics

1. Race (optional):

- White
- American Indian or Alaska Native
- Asian
- Black or African-American
- Native Hawaiian/Pacific Islander
- Hispanic or Latino

2. Ethnicity (optional):

- Not Hispanic or Latino
- Hispanic or Latino

3. Primary language:

- English
- Chinese
- Spanish
- Tagalog
- Other: _____

4. Highest education level completed:

- Elementary school
- Middle school
- High school
- Two-year college
- Four-year college
- Graduate school

Social History

5. Are there any cultural or religious beliefs/behaviors that might affect your care?

- No
- Yes – List: _____

6. With whom do you live?

- Live alone
- Spouse or domestic partner
- Other adult
- Child(ren)
- Parent(s)
- Other: _____

Employment/Work (Job/School/Play)

7. Current work status:

- Working full-time
- Working part-time
- Retired
- Not employed
- Disabled

8. Occupation:

- Homemaker
- Active duty military
- Full-time student
- Part-time student
- Other: _____

Growth and Development

9. Did you have typical development as a baby and child?

- Yes
- No – Explain: _____

10. Which is your dominant hand?

- Right
- Left
- Ambidextrous

Living Environment

11. Where do you live?

- Private home
- Private apartment
- Rented room
- Other: _____

12. Does your home have any of the following?

- None
- Stairs (no railing)
- Stairs (with railing)
- Ramps
- Elevator
- Uneven terrain
- Assistive devices in the bathroom

13. 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

14. Do you use any assistive devices or equipment?

- None
- Cane
- Walker or rollator
- Manual wheelchair
- Motorized wheelchair
- Glasses
- Hearing aids
- Other: _____

General Health Status

15. How would you rate your general health status?

- Excellent
- Good
- Fair
- Poor

16. 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

17. 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: _____

18. 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? _____
19. Have you ever used illegal drugs?
 No
 Yes – Explain: _____

20. 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? _____

21. Have you used tobacco in the past?
 No
 Yes
If yes:
 a. Year you quit smoking: _____

Family History

22. Have any family members had the following conditions?
 None
 Heart disease

- High blood pressure
 Stroke
 Diabetes
 Cancer
 Psychological conditions

- Arthritis
 Osteoporosis
 Other: _____

Medical/Surgical History

23. Cardiovascular:
 None
 High blood pressure
 Heart attack
 Heart disease
 High cholesterol
 Pacemaker
 Stroke
 Circulation problems
 Surgery: _____
 Other: _____
24. Endocrine/metabolic:
 None
 Diabetes or high blood sugar
 Low blood sugar
 Thyroid problems
 Other: _____
25. Gastrointestinal:
 None
 Constipation
 Ulcers
 Stomach problems
 Surgery: _____
 Other: _____
26. Genitourinary:
 None
 Prostate disease (males only)
 Kidney problems
 Surgery: _____
 Other: _____
27. Gynecological (females only):
 None
 Pelvic inflammatory disease
 Endometriosis
 Painful periods
 Trying to conceive
 Surgery: _____
 Other: _____
28. Integumentary/Skin:
 None
 Skin diseases
 Sensitive to heat
 Sensitive to cold
 Surgery: _____
 Other: _____

98. Musculoskeletal:
 None
 Motor vehicle accident
 Arthritis
 Broken bones
 Osteoporosis
 Hernia
 Surgery: _____
 Other: _____
30. Neurological/Brain:
 None
 Headaches
 Dizzy spells
 Seizures or epilepsy
 Head injury
 MS
 Parkinson disease
 Other: _____
31. Neuromuscular:
 None
 Balance problems
 Muscular dystrophy
 Other: _____
32. Obstetrical (females only):
 None
 # of pregnancies: _____
 # of vaginal births: _____
 # of cesarean births: _____
 Currently pregnant
 Date of most recent birth: _____
 Currently breastfeeding
 Other: _____
33. Psychological:
 None
 Depression
 Anxiety
 Other: _____
34. Pulmonary:
 None
 Asthma
 Lung problems
 Surgery: _____
 Other: _____

35. Prior hospitalizations and surgeries:
 None
 Yes – List: _____

36. Preexisting medical conditions:
 None
 Yes – List: _____

37. Other health-related conditions:
 None
 Cancer
 Vision problems
 Hearing problems
 Metal implants
 Other: _____
38. Allergies:
 None
 Yes – List: _____

39. 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

Current Condition/Chief Complaint

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

41. When did the problem start?

Date: _____

21. How did the problem start?

43. Have your symptoms changed since they started?

- No, stayed the same
- Yes, gotten worse
- Yes, gotten better

43. Other health care providers you are seeing for this problem:

- None
- Acupuncturist
- Chiropractor
- Primary care physician
- Massage therapist
- Podiatrist
- Specialist physician: _____
- Other: _____

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

46. Has this problem caused any of the following?

- None
- Financial problems
- Family problems
- Relationship problems
- Emotional problems

47. 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

48. 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: _____

49. Do you have difficulty with self-care activities?

- No difficulty
- Bathing
- Dressing
- Eating
- Toileting
- Other: _____

50. Do you have difficulty with home management activities?

- No difficulty
- Household chores
- Shopping
- Driving, transportation
- Taking care of dependents
- Preparing meals
- Other: _____

51. Do you have difficulty with community or work activities?

- No difficulty
- Work activities
- School activities
- Community activities
- Recreational activities
- Play activities
- Other: _____

Medications

52. Current medications: (Medicare patients SKIP THIS)

- None
- List: _____
- _____
- _____
- _____

53. Non-prescription medications or supplements: (Medicare patients SKIP THIS)

- None
- List: _____
- _____
- _____
- _____

54. Medications previously taken for current condition:

- None
- List: _____
- _____
- _____

Other Clinical Tests

55. Laboratory and diagnostic tests done:

- None
- X-ray

- MRI
- CT scan
- Arthroscopy
- Bone scan

- Nerve conduction velocity
- Exercise stress test
- Urine tests
- Other: _____

56. Height: _____ ft. _____ in.

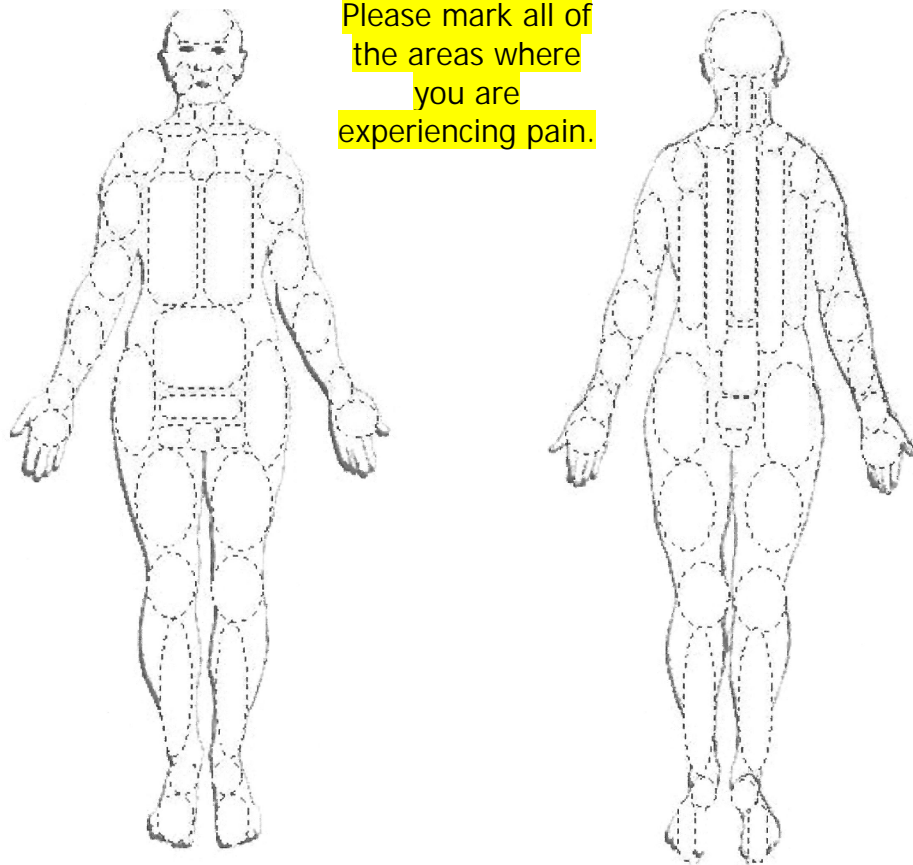
57. Weight: _____ lbs.

Patient signature: _____

Date: _____

Comprehensive Therapy Services, Inc.
858.457.8419

58. 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 |