PARADIGM PHYSICAL THERAPY & SPORTS SCIENCE CENTER

William H. Dodson, PT, DSc (ABD), OCS, CHT
Odessa Clinic, 701 N Grant 432-580-3300 432-580-0505 (fax)
Midland • Odessa • Monahans • Big Spring

Patient Information

__________ First __________ Middle __________ Last ____/____/____ Date

____-____-____ SSN # ____/____/____ Date of Birth ____ft.____in. Height ________lbs. Weight

Circle -- **Sex:** Male Female -- **Hand Dominance:** Right Left Both -- **Married?** Yes No -- **Student?** Yes No

__________ Address __________ City _____ State _____ Zip

(____) ________ Home Phone (____) ________ 2nd Phone ________ 2nd Phone Type (Work, Mobile, etc)

__________ Employer __________ Occupation (____) ________ Employer Phone

__________ Emergency Contact (____) ________ Emergency Contact Phone

If Patient is Under 18 Years of Age

__________ Name of Person Responsible (Guardian) __________ Relationship (____) ________ Guardian Phone

__________ Guardian Address __________ City _____ State _____ Zip

Injury / Problem

__________ Area of Injury __________ Referring Doctor ____/____/____ Injury Date

Circle -- Is the injury due to an auto accident? Yes No
If YES, have you filed this accident with your insurance company? Yes No

__________ Insurance Company Name (____) ________ Insurance Phone

__________ Claim Number ____/____/____ Date of Accident

If not auto, type of accident: Workers Comp No Fault Other__________

Circle -- **Are you currently receiving Home Health Care?** Yes No
If YES, Agency name / phone: __________ (____) ________

Circle -- **Are you with a Hospice Agency?** Yes No
If YES, Agency name / phone: __________ (____) ________

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Outpatient Intake

1. Current Problem(s)

a. Area(s) Injured: ______________________________
b. Date problem began: _____/_____/___________
c. Affected side: Right Left Bi-Lateral
d. Did you have surgery for the problem? Yes No If YES, date of surgery: _____/_____/___________
e. Please briefly describe what happened. ______________________________
____
____
f. What are you doing to care for the problem(s) now? ______________________________
g. Location of pain: ______________________________
h. Type of Pain (Check all that apply)

[ ] Ache [ ] Burn [ ] Cramp [ ] Dull [ ] Panic [ ] Pinch
[ ] Prick [ ] Pull [ ] Raw [ ] Sharp [ ] Smarting [ ] Sore
[ ] Stab [ ] Sting [ ] Tender [ ] Thorn [ ] Throbbing [ ] Tight
[ ] Tingling [ ] Twinge [ ] Other ______________________________

i. What is the feeling of the pain?

[ ] Internal [ ] External [ ] Acute [ ] Chronic [ ] Other ____________

j. What makes the pain / problem(s) worse? (Check all that apply)

[ ] Sitting [ ] Walking [ ] Reaching [ ] Driving
[ ] Squatting [ ] Lying Down [ ] Bending Over [ ] Cold Application
[ ] Arm Activities [ ] Heat Application [ ] Kneeling [ ] Hand Activities
[ ] Standing [ ] Climbing [ ] Other ______________________________

k. What makes the pain / problem(s) better? (Check all that apply)

[ ] Sitting [ ] Lying On Side [ ] Heat Application [ ] Lying Face Down
[ ] Standing [ ] Changing Positions [ ] Lying Face Up [ ] Cold Application
[ ] Nothing Helps [ ] Walking [ ] Taking Medication
[ ] Other ______________________________

l. What is your current pain level? (Circle only one) 0 1 2 3 4 5 6 7 8 9 10

Minimal Moderate Severe

m. What time of day is your pain worse?

[ ] Morning [ ] Afternoon [ ] Evening [ ] Night

n. What time of day is your pain best?

[ ] Morning [ ] Afternoon [ ] Evening [ ] Night

o. How often does the pain interfere with your activity or movement? (Check only one)

[ ] 0-No Pain / Interference [ ] 1-Less often than daily [ ] 2-Daily, but not constant [ ] 3-All the Time

p. What are your primary goals for physical therapy?

[ ] Injury Rehabilitation [ ] Improve Physical Condition [ ] Return to Work/Sports [ ] Decrease Pain
[ ] Other ______________________________

q. Are you seeing anyone else for the problem(s)? (Check all that apply)

[ ] Acupuncturist [ ] Obstetrician / Gynecologist [ ] Occupational Therapist [ ] Cardiologist
[ ] Chiropractor [ ] Orthopedist [ ] Dentist [ ] Osteopath
[ ] Family Practitioner [ ] Pediatrician [ ] Internist [ ] Podiatrist
[ ] Massage Therapist [ ] Primary Care Physician [ ] Neurologist [ ] Rheumatologist
[ ] Other ______________________________

2. Current Limitations (Check all that apply)

a. Difficulty with locomotion / movement:

[ ] Bed Mobility [ ] Transfers (bed to chair, bed to commode)

b. Difficulty with Gait (walking):

[ ] On Levels [ ] On Ramps [ ] On Stairs [ ] On Uneven Terrain

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c. Difficulty with daily activities:
   [ ] Difficulty with self-care (bathing, dressing, eating, toileting, etc.)
   [ ] Difficulty with home management (such as household chores, shopping, driving / transportation)
d. Difficulty with community and work activities / integration:
   [ ] Work / School [ ] Recreation or Play Activity

3. **Hand Dominance:** Right Left Both

4. **Race:**
   [ ] Afro-American [ ] Caucasian [ ] Native American [ ] Asian
   [ ] Hispanic [ ] Native Hawaiian [ ] Other ______________________

5. **Language: Is interpretation needed?** No Yes, Interpreter Needed (language)______________

6. **Cultural / Religious beliefs that might affect care?** Yes No If YES, please explain__________
   ____

7. **Education:**
   Highest Grade Completed: (circle one) 1 2 3 4 5 6 7 8 9 10 11 12
   [ ] Some College [ ] College Graduate [ ] Graduate School / Advanced Degree

8. **Employment:**
   [ ] Working Full Time [ ] Working Part Time [ ] Homemaker [ ] Retired
   [ ] Student [ ] Unemployed
   Occupation: ______________________ Last Day Worked: ______________

9. **Where do you live?**
   [ ] Private Home [ ] Apartment [ ] Rented Room [ ] Hospice
   [ ] Board and care / assisted living / group home [ ] Homeless (with or without shelter)
   [ ] Long-term care facility (nursing home) [ ] Other ______________________

10. **With whom do you live?**
   [ ] Alone [ ] Spouse only [ ] Family [ ] Other relative(s)
   [ ] Personal care attendant [ ] Other ______________________

11. **Does your home have…**?
   [ ] Ramps [ ] Stairs, no railing [ ] Stairs, railing [ ] Elevator
   [ ] Uneven Terrain [ ] Other obstacles ______________________

12. **Do you use**…?
   [ ] Cane [ ] Walker or Rollator [ ] Crutches [ ] Manual Wheelchair
   [ ] Motorized Wheelchair [ ] None [ ] Other ______________________

13. **Current Health:**
   a. Please rate your health:
      [ ] Excellent [ ] Good [ ] Fair [ ] Poor
   b. Have you had any major life changes during the past year? (such new baby, job change, death of a family member)
      [ ] Yes [ ] No

14. **Health Habits:**
   a. Do you exercise beyond normal daily activities / chores? Yes No
      i. On average, how many days per week ? ______________________
      ii. For how many minutes, on an average day? ______________________
      iii. What kind of exercise? ______________________

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b. Do you currently smoke tobacco? Yes No If YES, how many packs per day? ____________________
c. Have you smoked in the past? Yes No If YES, what year did you quit? ____________________
d. How many alcoholic beverages do you drink on average per week? ____________________

15. Family History:
Has any member of your immediate family (mother, father, brother, sister, aunt, uncle, grandparents) been diagnosed with any of the following?
[ ] Heart Disease [ ] Stroke [ ] Cancer [ ] Hypertension
[ ] Diabetes [ ] Other ____________________

16. Medication:
a. Do you take any prescription medications? Yes No
If YES, please list: ____________________
b. Do you have any nonprescription medications? (Check all that apply)
[ ] Advil / Aleve [ ] Herbal Supplements [ ] Ibuprofen / Naproxen [ ] Antacids
[ ] Antihistamines [ ] Tylenol [ ] Aspirin [ ] Decongestants
[ ] Other ____________________

17. Medical History
a. Please check if you have ever had:
[ ] Allergies [ ] Arthritis [ ] Asthma [ ] Blood Disorders
[ ] Broken Bones / Fractures [ ] Cancer [ ] Circulation / Vascular Problems
[ ] Depression [ ] Developmental or Growth Problems [ ] Diabetes / High Blood Sugar
[ ] Head Injury [ ] Heart Problems [ ] High Blood Pressure [ ] Kidney Problems
[ ] Infectious Disease (such as tuberculosis, hepatitis) [ ] Hypoglycemia / Low Blood Sugar
[ ] Lung Problems [ ] Multiple Sclerosis [ ] Muscular Dystrophy [ ] Osteoporosis
[ ] Parkinson's Disease [ ] Repeated Infections [ ] Seizures / Epilepsy [ ] Skin Diseases
[ ] Stroke [ ] Thyroid Problems [ ] Ulcers / Stomach Problems
b. (For Men) Have you been diagnosed with prostate disease? Yes No
c. (For Women) Have you been diagnosed with:
[ ] Pelvis Inflammatory Disease [ ] Endometriosis [ ] Trouble with your period
[ ] Complicated Pregnancies [ ] Pregnant, or think you might be

18. Have you ever had any other surgeries? Yes No
If YES, please describe and include dates. (Do not include surgery for current problem.)
____________________ ____/____/________
____________________ ____/____/________

19. Within the past year, have you had any of the following symptoms? (Check all that apply)
[ ] Bowel Problems [ ] Chest Pain [ ] Coordination Problems [ ] Cough
[ ] Difficulty Sleeping [ ] Difficulty Swallowing [ ] Difficulty Walking [ ] Dizziness /Blackouts
[ ] Fever / Chills / Sweats [ ] Headaches [ ] Hearing Problems [ ] Heart Palpitations
[ ] Hoarseness [ ] Joint Pain / Swelling [ ] Loss of Appetite [ ] Loss of Balance
[ ] Nausea / Vomiting [ ] Pain at Night [ ] Shortness of Breath [ ] Urinary Problems
[ ] Vision Problems [ ] Weakness in arms or legs [ ] Weight Loss / Gain

20. Within the past year, have you had any of the following medical tests? (Check all that apply)
[ ] Angiogram [ ] Arthroscopy [ ] Biopsy [ ] Blood Tests
[ ] Bone Scan [ ] Bronchoscopy [ ] CT Scan [ ] Doppler Ultrasound
[ ] Echocardiogram [ ] EEG (electroencephalogram) [ ] EKG (electrocardiogram) [ ] Mammogram
[ ] EMG (electromyogram) [ ] MRI [ ] Myelogram [ ] Pap Smear
[ ] NCV (nerve conduction velocity) [ ] Pulmonary Function Test [ ] Spinal Tap
[ ] Stool Test [ ] Stress Test (treadmill, bike) [ ] Urine Tests [ ] X-Rays

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Consent and Acknowledgement of Policy

Authorization to Release Information
I hereby authorize Paradigm Physical Therapy & Sports Science Center (hereafter referred to as Paradigm) to release any complete information acquired in the course of my prescribed treatment. I realize this information may be needed by my insurance company or referring physician.

Authorization to Pay Benefits to Paradigm
I hereby authorize payment directly to Paradigm for medical benefits, otherwise payable to me for services described.

Authorization for Payment
I hereby promise to pay Paradigm for any professional services rendered covered by my insurance or any balance due after insurance payment has been made.

Authorization for Treatment
I hereby request and authorize treatment from Paradigm and/or associated assistants of their choice and understand my responsibility for payment of this account regardless of insurance.

Acknowledgement of Receipt of Privacy Notice
I understand that as part of the provision of healthcare services, Paradigm creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

______________________________ ______________
Patient's Name (Printed) Date

______________________________ ______________________________
Patient's Signature (or Guardian, if a Minor) Witness (Optional)

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Insurance Information

Please circle your insurance of visit type below. If you select CPT-4, Personal Injury, Medicare, or Medicaid, please fill out the section which applies to your insurance type below. Any other type may return the sheet as is.

CPT-4 Personal Injury Medicare Medicaid Workers Comp. TRC FCE Impairment Rating

CPT-4 / Personal Injury

Primary Insurance ________ Insurance Phone (____) ________

Name of Policy Holder (if not you) ________ Policy Holder Date of Birth __/__/__ Relationship to Patient ________

Insured ID Number ________ Group Number ________

Policy Holder's Employer ________ Employer Phone (____) ________

Secondary Insurance ________ Insurance Phone (____) ________

Name of Policy Holder (if not you) ________ Policy Holder Date of Birth __/__/__ Relationship to Patient ________

Insured ID Number ________ Group Number ________

Policy Holder's Employer ________ Employer Phone (____) ________

Attorney Name (Personal Injury Only) ________ Attorney Phone (____) ________

Attorney Address ________ City ________ State ____ Zip ________

Medicare

Medicare is my primary insurance: Yes No

Medicare ID Number ________ Part B Effective Date* __/__/__

Secondary Insurance ________ Policy Number ________

Name of Policy Holder (if not you) ________ Policy Holder Date of Birth __/__/__ Policy Holder Social Security Num. ___-___-___

Medicaid

Medicaid is my primary insurance: Yes No

Medicaid ID Number ________

*Only Part B covers out-patient Physical Therapy