

DATE: \_\_\_\_\_

PATIENT #: \_\_\_\_\_ PROVIDER: \_\_\_\_\_

## PHYSICAL THERAPY INITIAL EVALUATION FORM

### PATIENT INFORMATION

NAME \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ lbs

WHICH DOCTOR IS MANAGING YOUR CONDITION?: \_\_\_\_\_

### REHAB INFORMATION

1. CHIEF COMPLAIN/AILMENT/INJURY \_\_\_\_\_

2. DATE OF INJURY \_\_\_\_\_ DATE OF SURGERY \_\_\_\_\_

3. BRIEFLY DESCRIBE HOW YOU WERE INJURED \_\_\_\_\_

4. HAVE YOU RECEIVED THERAPY FOR THIS CONDITION?  YES  NO WHEN? \_\_\_\_\_

5. HAS YOUR CONDITION BEEN GETTING:  WORSE  SAME  BETTER

6. ARE YOUR SYMPTOMS:  CONSTANT or  INTERMITTENT

7. MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

AT BEST:       0    1    2    3    4    5    6    7    8    9    10 (EXCRUCIATING PAIN)

AT WORST:     0    1    2    3    4    5    6    7    8    9    10 (EXCRUCIATING PAIN)

8. WHAT DECREASES PAIN /MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

- |                                  |   |                                     |   |
|----------------------------------|---|-------------------------------------|---|
| <input type="checkbox"/> BENDING | <input type="checkbox"/> MOVEMENT           | <input type="checkbox"/> REST       | <input type="checkbox"/> BETTER IN A.M.         |
| <input type="checkbox"/> SITTING | <input type="checkbox"/> STANDING           | <input type="checkbox"/> HEAT       | <input type="checkbox"/> BETTER AS DAY PROGRESS |
| <input type="checkbox"/> RISING  | <input type="checkbox"/> WALKING            | <input type="checkbox"/> ICE        | <input type="checkbox"/> BETTER IN P.M.         |
| <input type="checkbox"/> LYING   | <input type="checkbox"/> CHANGING POSITIONS | <input type="checkbox"/> MEDICATION | <input type="checkbox"/> N/A CAST JUST REMOVED  |

9. WHAT INCREASES PAIN /MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

- |                                  |  |                                      |  |
|----------------------------------|--|--------------------------------------|--|
| <input type="checkbox"/> BENDING | <input type="checkbox"/> MOVEMENT              | <input type="checkbox"/> STAIR       | <input type="checkbox"/> WORSE IN A.M.         |
| <input type="checkbox"/> SITTING | <input type="checkbox"/> STANDING              | <input type="checkbox"/> COUGH       | <input type="checkbox"/> WORSE AS DAY PROGRESS |
| <input type="checkbox"/> RISING  | <input type="checkbox"/> WALKING               | <input type="checkbox"/> SNEEZE      | <input type="checkbox"/> WORSE IN P.M.         |
| <input type="checkbox"/> LYING   | <input type="checkbox"/> CHANGING POSITIONS    | <input type="checkbox"/> DEEP BREATH | <input type="checkbox"/> N/A CAST JUST REMOVED |
| <input type="checkbox"/> REST    | <input type="checkbox"/> PROLONGED POSITIONING | <input type="checkbox"/> MEDICATION  |  |

10. PREVIOUS MEDICAL INTERVENTION (MARK ALL THAT APPLY)

X-RAY / MRI    CATSCAN    INJECTIONS   OTHER \_\_\_\_\_

11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY?

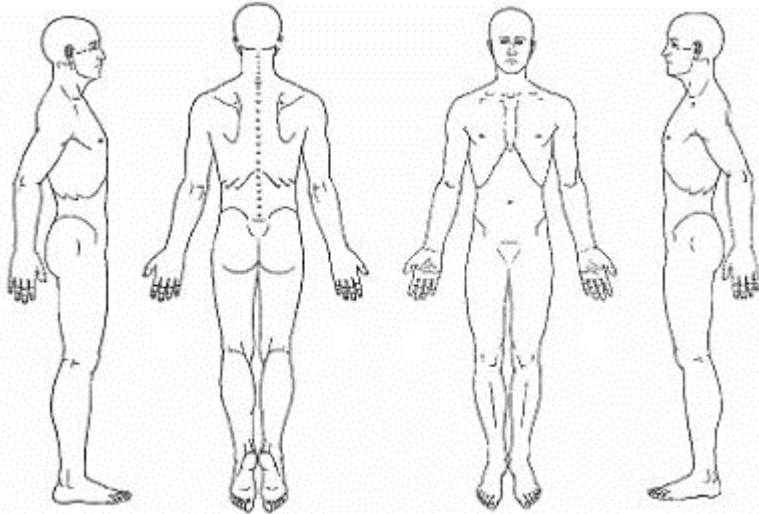
\_\_\_\_\_  
\_\_\_\_\_

DATE: \_\_\_\_\_

PATIENT #: \_\_\_\_\_

PROVIDER: \_\_\_\_\_

**DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS.**



SEVERE PAIN	*****
MODERATE PAIN	000000
ACHE / SORENESS	□□□□□
SHARP/STABBING PAIN	↓↑↓↑↓
NUMBNESS/TINGLING	XXXXXX

**MEDICAL INFORMATION (MARK ALL THAT APPLY)**

\*\*This information is confidential and remains part of your chart

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Blood Clots             |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Depression/Anxiety      | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Difficulty Swallowing   |
| <input type="checkbox"/> Epilepsy/Seizures     | <input type="checkbox"/> Fever/Chills/Sweats     | <input type="checkbox"/> Fibromyalgia      | <input type="checkbox"/> Heart Trouble           |
| <input type="checkbox"/> History of Drug Abuse | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> HIV/Hepatitis     | <input type="checkbox"/> Motion Sickness/Vertigo |
| <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Pregnancy         | <input type="checkbox"/> Shortness of breath     |
| <input type="checkbox"/> Stroke                | <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Other: _____      |  |

Previous Surgeries: \_\_\_\_\_

\_\_\_\_\_

Alcohol Consumption:  do not drink  1-7/wk  8-14/wk  15+/wk

Smoking:  Yes  No

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Hobbies/Sports: \_\_\_\_\_



Be Well. Live Well.

1470 East Valley Road, Suite M
Santa Barbara, CA 93108
Tel: (805) 565-5252
www.bissellclinic.com

Patient Information

Patient Name : \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security No: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Gender: [m] [f] Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you interested in nutritional counseling? [ ] YES [ ] NO

How did you hear about us? [ ] Google [ ] Yelp [ ] Mailer [ ] Facebook
[ ] Advertisement [ ] Patient: name of person that referred you to our office: \_\_\_\_\_

Employer Name & Phone: \_\_\_\_\_

Primary Care Physician Name & Phone: \_\_\_\_\_

May we contact your primary care physician? [ ] YES [ ] NO

Physical Therapy Patients with MEDICARE, please answer the following:

Are you receiving or have you recently received home health services? [ ] YES [ ] NO

Have you received other physical therapy services this year ? [ ] YES [ ] NO

## Bissell Clinic Consents & Office Policies

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Financial/Office Policies:** I understand and agree to the following policies implemented by Bissell Clinic:

- Payment is expected when services are rendered unless prior arrangements have been made.
- **48-hour notice of cancellation is required to avoid a charge for the missed appointment.**
- **24-hour notice (or less) of cancellation will result in the full fee charge for the missed appointment.**
- A \$50.00 service fee will be imposed for all checks returned for insufficient funds. Bissell Clinic will only submit claims to Medicare for patient reimbursement as a non-par provider. We can provide a *superbill* if you would like to submit to insurance for reimbursement. We recommend confirming you have out of network benefits.
- A 3.95% surcharge for all credit card transactions. This surcharge excludes Medicare, HSA and FSA patient payments.
- All accounts that are delinquent at 60 days are subject to a \$25 penalty and will be charged \$15 per bill, per month thereafter. Accounts will be reported to the credit bureau for collection at 90 days and charged a \$250 filing fee.

**Please Initial:** \_\_\_\_\_

**Informed Consent:** I hereby request and consent to the performance of chiropractic adjustments and procedures and/or various modes of physical therapy including stretches and exercises, performed on or by me (or on the patient named above, for whom I am legally responsible) by Dr. Bissell, Karen Still, M.S.P.T., Dwight Hank Peterson, P.T., Kimberly Courtney, D.P.T., and/or those working at the clinic.

I recognize that all health care procedures, including those used in this office, have risks associated with them. Risks, although rare, associated with chiropractic adjusting procedures may include minor aggravation of symptoms, musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome and stroke or death through complicating factors. Physical Therapy exercises and stretches may result in muscle soreness. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interests.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I hereby accept the risks associated with any care by the doctor, therapists, and their assistants and release Bissell Clinic of any liability for any injury or loss directly related to care I have received at this clinic.

**Please Initial:** \_\_\_\_\_

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**Authorization of Payment:** I hereby directly authorize Bissell Clinic the release of any medical records necessary to facilitate my treatment to process Medicare claims and otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees (Civil Code 1717) as may be required to affect collection.

I further understand that any charges incurred for services rendered by an ancillary provider, radiology facility, or another chiropractor or physical therapist as a result of a referral made by Bissell Clinic may or may not be reimbursable depending on that clinic's contracted status with my insurance company. I realize that it is my responsibility to check this information prior to consenting to the procedure or treatment.

**Please Initial:** \_\_\_\_\_

**You are responsible for payment at the time of service. If you prefer, you may leave your credit card on file. By signing below, you are authorizing us to make current and future charges to your card.**

Card # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

CVV: \_\_\_\_\_

Signature \_\_\_\_\_

**Treatment of Minors:** I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. I authorize Dr. Bissell, Karen Still, P.T., Dwight Hank Peterson, P.T., Kimberly Courtney, D.P.T., & /or whomever they may designate as their assistant to administer treatment as deemed necessary.

**Please Initial:** \_\_\_\_\_

**Notice of Privacy Practices:** Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosure for the purpose of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage & preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

I acknowledge receipt of Notice of Privacy Practices.

**Please Initial:** \_\_\_\_\_

**I certify that all the information provided herein is true & correct.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_