

(Please Print Clearly)

Patient's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Patient's SS#: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ DL #: \_\_\_\_\_ Gender:  Male  Female

Hm. Ph#: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
(Recipient of surveys, aptm confirmation, etc)

Patient's Status:  Married  Single  Divorced  Widowed  Other Student:  Full-time  Part-time

Employment Status:  Full-time  Part-time  Unemployed  Self-Employed  Retired  Disabled

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

Wk. #: (\_\_\_\_) \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Spouse's SS#: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Spouse's Place of Employment: \_\_\_\_\_ WK#: (\_\_\_\_) \_\_\_\_\_

Responsible Party/Guardian: (If not the patient; or If patient is a minor (under the age of 18):

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ DL #: \_\_\_\_\_ Hm. Ph#: (\_\_\_\_) \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_

Place of Employment \_\_\_\_\_ Wk. #: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ # (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

**Are you currently a wellness member here at MTS-LGH Therapy Services LLC?**  Yes  No

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:**

I authorize the release of any and all medical information necessary to process my claim for services provided by MTS-LGH Therapy Services LLC, and request payment of benefits to MTS-LGH Therapy Services LLC.

I hereby consent to the release and disclosure of my personal health information to MTS-LGH Therapy Services LLC. This release authorization includes my personal health information consisting of MRI results, test results, etc. for the purpose of deciding plan of treatment. I understand that MTS-LGH Therapy Services LLC is permitted to send me unencrypted emails that pertains personal health information if advised by me and I am aware of the risk.

Patient's/Responsible Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## MTS-LGH Therapy Services LLC Patient Information Acknowledgement Form

I have read and fully understand MTS-LGH Therapy Services LLC's Notice of Information Practices. I understand that MTS-LGH Therapy Services LLC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that MTS-LGH Therapy Services, LLC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby authorize the use and disclosure of my personal health information for purposes as noted in MTS-LGH Therapy Services LLC Notice of Information practices. I understand that I retain the right to revoke this authorization by notifying the practice in writing at any time.

I would like a copy of my initial evaluation sent to my home address.  Yes  No

\_\_\_\_\_  
Patient Name

### Designated Individuals Authorization Form

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

#### Authorized Designees:

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

**Please list any preferred physician's involved in your care: (Example: General/Family Physician, Orthopedist, Neurologist, Cardiologist, etc).**

Physician's Name: _____	Specialty: _____
Physician's Name: _____	Specialty: _____
Physician's Name: _____	Specialty: _____
Physician's Name: _____	Specialty: _____

### No Show Policy

In order for MTS-LGH Therapy Services LLC to effectively give the best possible treatment and care for our patient, it is imperative that our patients attend their scheduled appointments as referred by their physicians. If you are unable to attend your scheduled appointment, as a courtesy to our office, we ask that you call prior to your appointment time to cancel that appointment. If you consistently miss your scheduled appointments, our office will refrain from scheduling your next appointment, discontinue your treatment and notify your physician of your inability to keep your scheduled appointments. As a result, you will be required to see your physician for a new referral before returning to us for treatment.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date completed: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Return Date to Physician: \_\_\_\_\_

Are you receiving home health? Yes No If yes, Agency Name: \_\_\_\_\_ PH#: \_\_\_\_\_

(PLEASE NOTE: If you are a Medicare patient and you are receiving home health, Medicare will not pay for you to have outpatient PT & home health at the same time, please let the receptionist know immediately if this applies to you)

What caused you to seek physical therapy/medical attention? \_\_\_\_\_

Your condition is related to: Employment Auto Accident Home Other

Date of condition/accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ State Accident Occurred: \_\_\_\_\_

What is your major complaint? Please be as detailed as possible \_\_\_\_\_  
\_\_\_\_\_

Have you had this problem before? \_\_\_ Yes \_\_\_ No

Mark the location of your pain with an "X":

FRONT

BACK

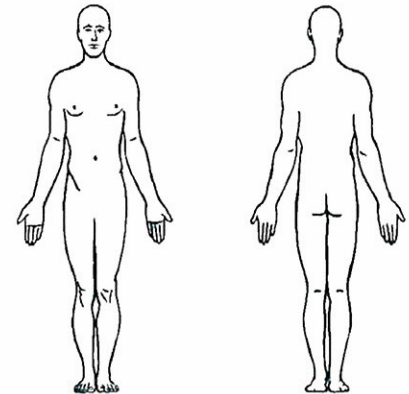
If you have pain, what is your pain level?

(0= No Pain, 10 = Extreme Pain – Circle)

AT WORST: | | | | | | | | | | |  
0 1 2 3 4 5 6 7 8 9 10

AT BEST: | | | | | | | | | | |  
0 1 2 3 4 5 6 7 8 9 10

CURRENTLY: | | | | | | | | | | |  
0 1 2 3 4 5 6 7 8 9 10



Are your symptoms: \_\_\_ Constant \_\_\_ Come & Go \_\_\_ Ache \_\_\_ Deep \_\_\_ Superficial \_\_\_ Dull \_\_\_ Sharp  
\_\_\_ Shooting \_\_\_ Burning \_\_\_ Numbness/Tingling Other: \_\_\_\_\_

Does your pain seem to be WORSE at a certain time of day? \_\_\_ Yes \_\_\_ No

If Yes, \_\_\_ Morning \_\_\_ Night Other: \_\_\_\_\_

Does your pain progress as the day goes along? \_\_\_ Yes \_\_\_ No If Yes, please explain: \_\_\_\_\_

Do you have difficulty falling asleep? \_\_\_ Yes \_\_\_ No If Yes, please explain: \_\_\_\_\_

Do you wake due to pain? \_\_\_ Yes \_\_\_ No If Yes, # of times per night: \_\_\_\_\_

What were you doing prior to this injury that you are unable to do currently?

\_\_\_ Squatting \_\_\_ Sitting \_\_\_ Driving \_\_\_ Reaching \_\_\_ Work Tasks \_\_\_ Holding/Carrying Objects

\_\_\_ Lifting \_\_\_ Walking \_\_\_ Gripping/Pinching \_\_\_ Dressing/Grooming \_\_\_ Stairs \_\_\_ Position Change

\_\_\_ Kneeling \_\_\_ Standing Other: \_\_\_\_\_

What household duties are you having difficulty performing?  Cooking  Cleaning  Vacuuming  
 Laundry  Yard Work  Grocery Shopping Other: \_\_\_\_\_

Do you use an assistive device?  None  Cane  Walker  Wheelchair Other: \_\_\_\_\_

Did you use an assistive device prior to current injury/condition?  Yes  No

What activities make your pain better? \_\_\_\_\_

What activities make your pain worse? \_\_\_\_\_

Is this pain getting:  Better  Worse  Not Changing

What type of treatments have you received for this condition?  X-Rays  Surgery  
 Chiropractic  MRI  Medications  Injection  Bone Scan  CT/CAT Scan  
 Physical Therapy  Home Health Please describe (agency, etc.) \_\_\_\_\_

Have you fallen in the last 12 months? Yes No If yes, how many times? \_\_\_\_\_

Did your fall result in any injury? Yes No \_\_\_\_\_

**PLEASE CHECK ALL PROBLEMS DIAGNOSED BY A DOCTOR. CIRCLE IF YOU ARE CURRENTLY BEING TREATED.**

Bronchitis/Emphysema/Lung Disease /COPD  Sciatica  Osteoporosis/penia  Heart Disease

Pneumonia  Fibromyalgia  Implants  Lupus

Abnormal Chest X-Ray  Bursitis  High/Low Blood Pressure  Tuberculosis

Chronic Fatigue Syndrome  TMJ Dysfunction  Dizziness/Fainting Spells  Epilepsy

Thrombosis/Phlebitis  Muscular Dystrophy  Pregnant – due \_\_\_\_\_  Diabetes

Rheumatoid Arthritis  Blood Thinner  Immunosuppression  Gout

Carpal Tunnel Syndrome  Blood-Borne Pathologies: HIV AIDS Hepatitis A Hepatitis B Hepatitis C

Tumors/ Cancer—Year \_\_\_\_\_ Type \_\_\_\_\_ Remission: Yes No

Pace Maker—if Yes, date rec'd \_\_\_\_\_

Sprains/ Dislocations/Broken Bones—Please List: \_\_\_\_\_

Please list all medications you are currently taking and what they are for [Specific name of medication, dosage, frequency & Route (Example: by mouth), please include over the counter, prescriptions, herbals & vitamins]:

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

Please list any previous surgeries: \_\_\_\_\_

\_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_