



**LINCOLN PHYSICAL THERAPY**  
— AND SPORTS REHAB, LLC —

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex M \_\_\_ F \_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Marital Status: S \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_

E-Mail Address \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_ Employer Phone # \_\_\_\_\_

Emergency Contact: Name/Phone # \_\_\_\_\_

If Married, Name of Spouse \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Spouse's Social Security Number \_\_\_\_\_ Spouse's Phone # \_\_\_\_\_

**IS YOUR VISIT RELATED TO WORKERS COMPENSATION / 3<sup>RD</sup> PARTY LIABILITY / MOTOR VEHICLE?** Yes \_\_\_ No \_\_\_

If "no" skip to Private Health Insurance Section below. If "yes", please circle related case: Work Comp / Liability / Motor Vehicle

Date of Injury \_\_\_\_\_ Where/How injury occurred \_\_\_\_\_

Employer/Carrier Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Case Manager/Employer Contact/Attorney Name \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_ Claim # \_\_\_\_\_

**PRIVATE HEALTH INSURANCE:**

**HAVE YOU RECEIVED ANY OF THE FOLLOWING TREATMENT DURING YOUR CURRENT INSURANCE PLAN YEAR?**

Physical Therapy? Yes \_\_\_ No \_\_\_ Home Health? Yes \_\_\_ No \_\_\_ Chiropractic Care? Yes \_\_\_ No \_\_\_

If yes to any, please specify name of facility and number of visits to each \_\_\_\_\_

Primary Insurance (circle one): BC/BS Coventry Midlands Choice UHC Medicare Medicare Replacement Medicaid Other

Other Insurance \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

**If insured is other than patient** (ie: spouse, parent, etc.):

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**AUTHORIZATION:** By signing this form, I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered. I also understand that I am responsible for payment of my medical bills regardless of the type of insurance coverage I have.

Lincoln Physical Therapy & Sports Rehab, LLC will bill your insurance on your behalf and make all reasonable efforts to obtain payment. **Finance Charge:** A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the items was added to the account. This charge will be computed at the rate of 1.25% or an annual percentage rate of 15%. **No Show Fee:** A fee of \$25.00 will be charged for any missed appointment or appointments cancelled less than 4 business hours prior to your scheduled appointment time.

Signature of Patient/Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_



## ***Referral Information***

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

***Why did you choose us? (Primary Reason for Coming Here)***

\_\_\_ **Recommended by Friend/Family member** Name \_\_\_\_\_

\_\_\_ **Recommended by Physician/Physician assistant** Name \_\_\_\_\_

\_\_\_ **Recommended by Nurse/Nurse practitioner** Name \_\_\_\_\_

\_\_\_ **Recommended by Employer** Name \_\_\_\_\_

\_\_\_ **Recommended by Coach/Trainer** Name \_\_\_\_\_

\_\_\_ **Other** \_\_\_\_\_

***Please help us and let us know where you may have seen or heard our ads. Check all that apply.***

\_\_\_ Sign/Banner: Location \_\_\_\_\_

\_\_\_ Internet Search Engine

\_\_\_ Church Bulletin \_\_\_\_\_

\_\_\_ Facebook

\_\_\_ Lincoln Orthopedic Center Magazine

\_\_\_ Other website \_\_\_\_\_

\_\_\_ White Pages

\_\_\_ Other

\_\_\_ LincolnPT.com website

\_\_\_ Facebook

\_\_\_ Whitepages/Yellowpages.com

\_\_\_\_\_

**Medical Information**

Family Physician \_\_\_\_\_

Referring Physician if not noted above \_\_\_\_\_



**PHYSICAL THERAPY PATIENT QUESTIONNAIRE**

**Patient Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Gender:** M / F **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Are you currently working:** Yes / No **What percent of your workday do you sit?** \_\_\_\_\_ **Stand?** \_\_\_\_\_

**Are you a tobacco smoker?** Never / Former / Current **If former or current tobacco smoker - Packs/Day** \_\_\_\_\_

**Are you, or could you be, pregnant:** Yes / No

**Do you exercise at least 3 days per week?** Yes / No

**PAST MEDICAL HISTORY**

**Have you ever been told that you have or had the following (circle Yes or No):**

Cancer	Yes	No	Heart Disease	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No	Osteoarthritis	Yes	No
Ulcers	Yes	No	Liver Disease	Yes	No	Rheumatoid Arthritis	Yes	No
Stroke	Yes	No	Osteoporosis	Yes	No	Hepatitis (A, B or C)	Yes	No
Allergies	Yes	No	Fibromyalgia	Yes	No	HIV	Yes	No
Type _____			Angina/Chest Pain	Yes	No	Other _____	Yes	No
Asthma	Yes	No	Lung Disease (COPD)	Yes	No			

**In the past 3 months, have you experienced any of the following?:**

Dizziness	Yes	No	Change in appetite	Yes	No	Bowel/bladder changes	Yes	No
Headaches	Yes	No	Numbness/tingling	Yes	No	Unexplained weight loss	Yes	No
Depression	Yes	No	Fever/chills/sweats	Yes	No	Pain w/coughing/sneezing	Yes	No
Nausea/vomiting	Yes	No	Difficulty swallowing	Yes	No			
Falls/poor balance	Yes	No	Increased pain at night	Yes	No			

**Past Surgical History (surgery & date):** \_\_\_\_\_

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

**Current Medications (current list can be given to front desk to copy instead of writing here):** \_\_\_\_\_

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

**Preferred spoken language:** \_\_\_\_\_ **Visually impaired?** Yes / No **Hearing impaired?** Yes / No

**Please indicate your learning preference (circle):** Demonstration / Written materials / Both

**Please rate your level of agreement with this statement: "I should not do physical activities which (might) make my pain worse."**  
Completely Disagree / Somewhat Disagree / Unsure / Somewhat Agree / Completely Agree

# PHYSICAL THERAPY PATIENT QUESTIONNAIRE

## PRIMARY COMPLAINT

What date (approximately) did your present pain start? \_\_\_\_\_

How did your pain start? \_\_\_\_\_

Are your symptoms currently (circle one): Getting better / About the same / Getting worse

What treatments have you received for this problem so far? \_\_\_\_\_

What makes your symptoms better? \_\_\_\_\_

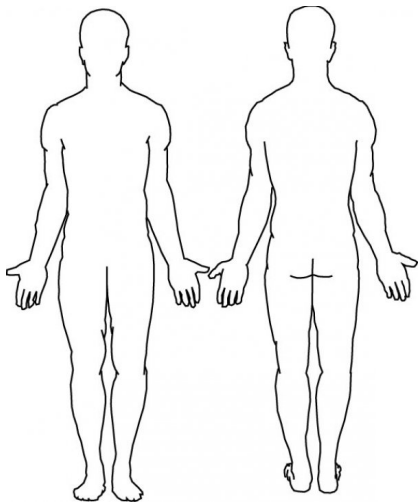
What makes your symptoms worse? \_\_\_\_\_





Have you had an x-ray, MRI or other imaging study for this problem? Yes / No

If yes, what type of imaging? \_\_\_\_\_ Where were they taken \_\_\_\_\_

Have you had similar symptoms in the past? Yes / No If so, when? \_\_\_\_\_

**BODY DIAGRAM:** Please mark the areas where you feel pain on the chart below.



-  Ache
-  Shooting Pain
-  Pins & Needles or Numbness & Tingling
-  Sharp Pain

Please mark the type and location of your pain on the pictures.

**Pain Scale:** On this scale from 0-10, please circle the number which best represents your pain:

**At worst, my pain is:** No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst pain imaginable**

**Currently my pain is:** No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst pain imaginable**

**At best, my pain is:** No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst pain imaginable**

**Please circle the number below which best represents your overall average level of function:**

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 Able to do everything

**How are you able to sleep at night (circle)?** Fine Moderate difficulty Only with Medication

**Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**What are your personal goals for therapy at this time?** \_\_\_\_\_



## New Patient Consent to the Use & Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I, \_\_\_\_\_, understand that as part of my health care, Lincoln Physical Therapy and Sports Rehab, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment. I understand that this information serves as;

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

Lincoln Physical Therapy and Sports Rehab, LLC will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions you must make your request in writing in the space below. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance upon this consent. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Lincoln Physical Therapy and Sports Rehab, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should they change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

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Due to HIPAA rules, if you would like your spouse, family member, or friend to have access to your account or health information, you will need to list their names and connection to you below:

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I understand that as part of this organization's treatment, payment, or health care operation, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and ( ) accept ( ) decline the terms of this consent.

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

If you are signing as the patient's representative:

Patient Representative (Please Print Name) \_\_\_\_\_

Patient Representative Signature \_\_\_\_\_

Describe your authority \_\_\_\_\_