



LAFAYETTE PHYSICAL THERAPY, INC.

Patient Information

Last Name	First Name	MI	Sex M F	Marital Status
Home Phone Cell/Alternate	SSN	DOB		AGE
Address (No P.O. boxes please)	City	State		Zip
Employer	Occupation	Work Phone		
Employer Address	City	State	Zip	
Guarantor/Guardian Name	Relation	Phone		
Emergency Contact Person	Relation	Phone		
Referring Doctor	How did you hear about us? <input type="checkbox"/> Doctor <input type="checkbox"/> I am returning <input type="checkbox"/> Website <input type="checkbox"/> Internet Search <input type="checkbox"/> Friend/Family <input type="checkbox"/> Other: _____			
Automated Appt. Reminders: Please select one phone number &/or e-mail to receive appt. reminder notifications on <input type="checkbox"/> Home <input type="checkbox"/> Cell/Alternate <input type="checkbox"/> Work <input type="checkbox"/> Email: _____ <input type="checkbox"/> No reminder				
Would you like to receive our e-mail newsletter – sent approximately 2 times per year? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Private Pay Client Policies and Agreements

Thank you for choosing Lafayette Physical Therapy for your physical therapy needs. We look forward to a rewarding relationship with you throughout your plan of care. The policies below are important to our relationship and assist us in providing you with the best quality care. Please let our staff know if you have any questions.

- 1. Payment:** Clients who are being treated on a Private Pay basis are required to pay at the time of service.

Initial
- 2. Account Responsibility:** I understand that I am responsible for the full payment for these services. Lafayette Physical Therapy will not bill your insurance.

Initial
- 3. Late Policy:** Please be on time for your appointments. A professional staff member has been scheduled to treat you specifically. If you are late by 10 minutes or more you may be required to reschedule or wait for the next available appointment. If you are unable to be seen due to tardiness you will be charged the no show fee below. If you are running late please call our office as soon as possible so we can attempt to accommodate you at a later time.

Initial
- 4. No Show & Cancellation Policy:** Our professional staffing is planned to accommodate scheduled visits. There is a \$65.00 charge for no show or same day cancellations (cancellations with less than a 24 hour notice for Tue-Fri appointments and notice after 3pm Friday for Monday appointments). LPT may discharge patients who fail to attend their scheduled appointments.

Initial
- 5. Overdue Accounts & Fees:** Balances are due upon receipt of a statement or being notified by the front desk. Accounts 60 days or more overdue may be assessed a late fee of \$25 and assigned to a collections agency (Transworld Collection Agency). A \$25.00 fee will apply to any returned checks.

Initial

Private Pay Client Policies & Agreements Continued

Continued on Back ↗



LAFAYETTE PHYSICAL THERAPY, INC.

Medical History and Pain Questionnaire

Name: _____ Date: _____ Age: _____

1) Have you ever had any of the following problems or conditions?

Now	Past	Never		Now	Past	Never		Now	Past	Never	
<u>Heart Disease</u>											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure (CHF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure Meds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coronary Artery Bypass Graft (CABG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Atherosclerotic Disease (CAD)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina
<u>Lung Disease</u>											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia				
<u>Vascular Disease</u>											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acquired Respiratory Distress Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Artery Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes				
<u>General Medical Conditions</u>											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (rheumatoid/osteoarthritis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastro Intestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney, bladder, prostate, urination problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic Disorders - MS, parkinsons, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/ Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metal pins/plates post fracture
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Visual Impairment - cataracts, glaucoma, macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, HIV, or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MERSA/Staph infections/other infections* Specify
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain (neck pain, low back pain, degenerative disk disease, spinal stenosis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis/ Implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment: very hard of hearing, even w/hearing aids
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Specify)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/ Panic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures

If **YES** to any of the above, please explain:

PLEASE FILL OUT BACK PAGE ↗

2) Have you ever had **Physical Therapy** treatment before? Yes No

If yes, when and what was it for? _____

3) Have you ever taken **steroids (ie: asthma inhalers)** for an extended period of time? Yes No

4) Have you ever taken **anti-coagulants (ie: Aspirin)** for an extended period of time? Yes No

5) Do you **smoke**? Yes No If yes, how much and how often? _____

6) Have you had an **unusual weight loss or gain** recently? Yes No

7) Please list **ALL surgical procedures** you have had in the past and give the dates if possible:

8) Please list **recent diagnostic studies (X-Ray, MRI, CAT, etc.)** and give dates if possible:

9) List any **medications** you are now taking. (Prescribed and over the counter: provide list if available)

10) Briefly describe the **history of your present injury, accident, or illness:** **Date of Injury:** _____

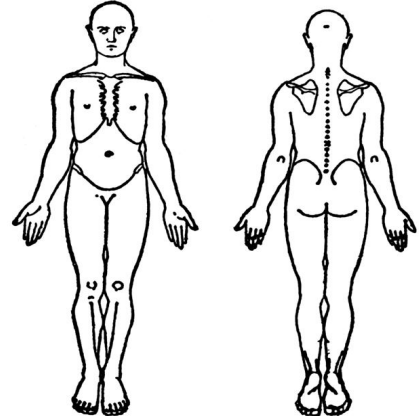
11) Do you have any pain with your condition? Yes No [If "Yes", please answer 11a-c]

a) What **aggravates** your pain?

- Bending Twisting Reaching
 Sitting Standing Walking
 Driving Other: _____

b) What **eases** your pain?

- Stretching Standing Changing Positions
 Lying Down Cold No Movement
 Walking Heat Massage
 Sitting Other: _____



c) For the **current** condition, on a scale of **0 to 10**

Visual Analog Scale: 0 Being no pain, and 10 being worst pain ever.

What is your: Pain level **today**: _____ Pain at its **best**: _____ Pain at its **worst**: _____

12) Please **indicate and describe** on the body chart the **area of your problem(s) and/or your discomfort.**

13) Have you **fallen** in the past year? Yes, ____ times. No

If Yes, Did you sustain any **injuries** from the fall(s)? Yes No

Please explain the circumstances surrounding the fall(s) that you are reporting above, including injuries.

Patient Signature

Date