

**FLORIDA GULFCOAST PHYSICAL THERAPY - PATIENT INFORMATION SHEET**

**Patient Name** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Temporary Address Street** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Permanent Address Street** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

**Social Security #** \_\_\_\_\_ **Birthdate** \_\_\_\_\_

Circle one:      Male                  Female

Marital Status: (circle one)      Single                  Married                  Divorced                  Separated                  Widowed

Date of injury/surgery OR onset of symptoms: **BE SPECIFIC (ACTUAL MM/DD/YY)** \_\_\_\_\_

Possible cause for injury? (example: fall or surgery) \_\_\_\_\_

Injury related to: (circle)    WORK                  AUTO ACCIDENT                  If so, did you report injury? YES                  NO

Have you received Home Health Services for this condition?                  YES                  NO

If so, name of **Home Health Company and phone number:** \_\_\_\_\_

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

Address Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Worker's compensation contact: Name \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance company \_\_\_\_\_

Customer service phone # (usually a 1-800 number) \_\_\_\_\_

Has your deductible for therapy services been met for the current year? \_\_\_\_\_

Thank you for your cooperation. If you are unable to keep your scheduled appointments, please notify us within 24 hours before the scheduled time. A \$25 fee will be assessed for missed appointments without a 24 hours notice. I have read and understand the policy regarding the fees and agree to pay any remaining balance. I authorize payment directly to Florida GulfCoast Physical Therapy. I authorize consent to copy and release PT records of treatment, charges, and reports to physicians and other parties, as indicated.

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

*For office use only:*

Diagnosis: \_\_\_\_\_ ICD-9 code: \_\_\_\_\_

Referring physician: \_\_\_\_\_ UPIN #: \_\_\_\_\_

Date of prescription: \_\_\_\_\_ Date of 1<sup>st</sup> Treatment: \_\_\_\_\_

Therapist: \_\_\_\_\_

**SUBJECTIVE EVALUATION FORM**

1. Patient Name: \_\_\_\_\_

2. Diagnosis/Complaint: \_\_\_\_\_

3. Date of injury or onset of the symptoms: \_\_\_\_\_ Date of surgery: \_\_\_\_\_

4. Symptoms: \_\_\_\_\_

5. Tests: (circle) Xray MRI CT EMG Bone Scan Arthrogram

Results: \_\_\_\_\_

6. Describe your pain: (circle) Sharp Dull Ache Shooting Stiffness

Other: \_\_\_\_\_

7. Do you experience any: (circle) Numbness Tingling Weakness Cramping

8. What increase your symptoms: \_\_\_\_\_

9. What decreases your symptoms: (positioning/activities) \_\_\_\_\_

10. List medications: (how often)

Pain medication: \_\_\_\_\_

Muscle relaxant: \_\_\_\_\_

Anti-inflammatory: \_\_\_\_\_

Other: \_\_\_\_\_

11. Do symptoms increase towards the end of the day? \_\_\_\_\_

12. Are you able to work? \_\_\_\_\_

13. Occupation: \_\_\_\_\_ Full time \_\_\_\_\_ Part time \_\_\_\_\_

14. Any past problems of this same nature: \_\_\_\_\_

15. Please check if you have any of the following:

- |   |  |                                    |
|---|--|------------------------------------|
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Frequent headaches         | <input type="checkbox"/> Chest pains   | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> High / low blood pressure  | <input type="checkbox"/> Pregnant      | <input type="checkbox"/> Epilepsy  |
| <input type="checkbox"/> Frequent nausea / vomiting | <input type="checkbox"/> Fainting      |                                    |
| <input type="checkbox"/> Excessive bleeding         | <input type="checkbox"/> Diabetes      |                                    |

16. Any other conditions the therapist should know about: \_\_\_\_\_

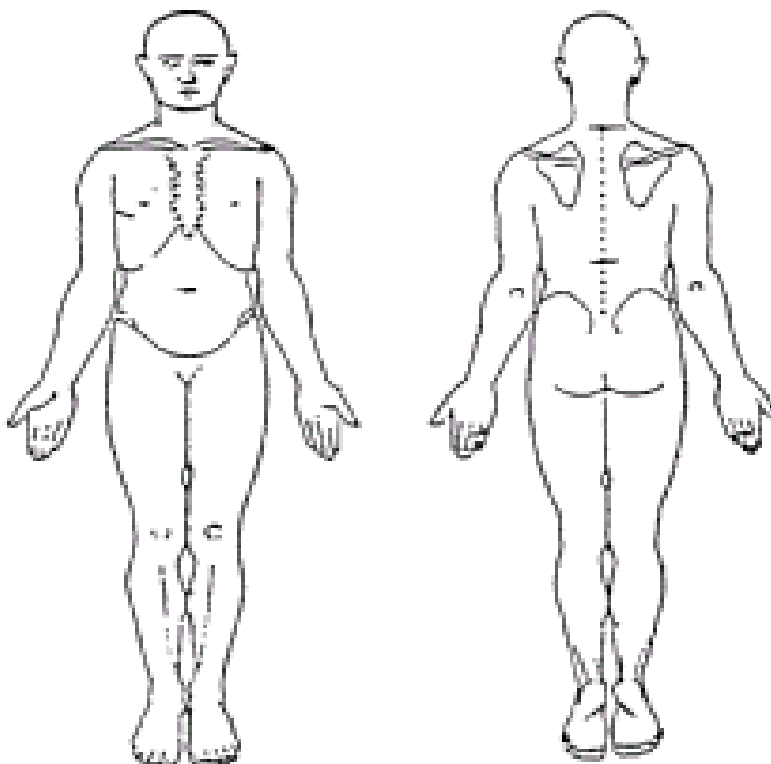
17. List any communicable diseases or infections: \_\_\_\_\_

18. What do you hope to achieve through therapy: \_\_\_\_\_

19. When is your next doctor's appointment: \_\_\_\_\_

## Lewis Patient Pain Index

Put an 'X' on the diagram where you feel pain. Put a check mark in the box that describes how often your pain occurs, and check whether it affects your sleep.



- |  |   |
|--|---|
| <input type="checkbox"/> Constant                            | <input type="checkbox"/> Wakes from sleep   |
| <input type="checkbox"/> Comes and goes at regular intervals | <input type="checkbox"/> Prevents sleep     |
| <input type="checkbox"/> Happens once in awhile              | <input type="checkbox"/> Better after sleep |

### **RATE YOUR PAIN LEVEL**

**Place a mark on the line to indicate your pain level at it's worst and at it's best**

0 \_\_\_\_\_ 10

No pain

Moderate pain

10 Seconds of this pain is unbearable or it causes you to go to the emergency room

### ADL ASSESSMENT

FUNCTIONAL STATUS	DATE:	ADDITIONAL NOTES
Are you able to perform: Daily Living Activities (cooking, eating, etc.)? Work Activities?	Y OR N Y OR N	
Can you manage all personal care (bathing, combing hair, brushing teeth, etc.) without symptoms?	Y OR N	
Can you dress independently: Shirt? Bra? Pants? Shoes?	Y OR N Y OR N Y OR N Y OR N	
Is your sleep interrupted by pain?	Y OR N	
Do you experience headaches?	Y OR N	
Can you concentrate for reading as much as you want without increased symptoms?	Y OR N	
Are you able to engage in your normal recreational or sports activities without symptoms?	Y OR N	
Can you sit as long as you want without increased symptoms?	Y OR N	
Can you stand as long as you want without increased symptoms?	Y OR N	
How far can you reach: Waist Level? Shoulder Level? Above Shoulder Level?	Y OR N Y OR N Y OR N	
Can you lift and carry items without pain? Groceries? Dishes? Laundry?	Y OR N Y OR N Y OR N	
Can you independently get out of: Chair? Car?	Y OR N Y OR N	
Can you squat without support of you arms?	Y OR N	
Does your problem interfere with you driving safely?	Y OR N	
Do you need an assistive device for walking? If so, did you use the assistive device before your problem began?	Y OR N Y OR N	
Can you walk: Pain free? For household chores? For errands within the community?	Y OR N Y OR N Y OR N	
Does your problem limit your walking? If your walking is limited, how many minutes can you walk before your symptoms increase?	Y OR N _____ mins.	
Can you perform stair climbing? How many steps can you climb? Do you have to use a handrail? Do you have to use an assistive device?	Y OR N ___ steps/flights Y OR N Y OR N	
Do you feel safe walking without a cane or walker: Indoors Outdoors on level terrain Outdoors on uneven terrain	Y OR N Y OR N Y OR N	

ADDITIONAL NOTES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



---

**Patient Responsibilities**

Welcome to Florida GulCoast Physical Therapy. We provide the latest in physical therapy services and our staff is committed to providing the most optimal care for each patient through our treatment plans and patient/family education.

We would like to acquaint you with our policies and procedures in order to serve you better.

**Office Hours:** Monday through Friday from 8:00 am until 5:00 pm. Clinical hours may vary according to therapist schedule. If calling before 8:00 am or after 5:00 pm, please leave a message with our service by dialing 948-2222.

**Scheduling:** While every attempt is made to maintain a consistent schedule that is amenable to each patient, variables such as a patient requiring specific equipment and/or individual therapist caseload may result in schedule changes. We cannot guarantee that each week your schedule will remain constant – **please check your schedule each week.** Your understanding and cooperation is appreciated.

If you have had previous difficulty remembering your schedule and would like a “reminder” call, please speak with our office, arrangements will be made to assist in special cases, as needed.

**Conflicts can be avoided** – keep our office staff informed of any pre-existing obligations (doctor’s visits and other appointments) as far in advance as possible. Our staff is scheduling 10 – 14 days ahead. If your status changes following a doctor’s appointment, please call to alert our office of a discharge or hold status.

**Cancellations:** If it is necessary for you to cancel your scheduled appointment, please notify our office as early as possible (24 hours notice is appreciated); this allows us to make maximum use of professional time and schedule those patients who may be waiting patiently on a waiting list.

**No Shows:** No shows are missed appointments without notifying our office, or less than three hours notification of a cancelled appointment. No shows are not guaranteed their next scheduled time will be held – it is the patient’s responsibility to call and verify their current schedule.

**Billing:** The billing procedure for Florida GulfCoast Physical Therapy is conducted in house. Questions you might have regarding your bill may be answered by calling 948-2222. Third party payors are billed directly by our office. Patients are responsible for any deductible and/or services the third party payor does not cover.

**Insurance:** Patients are responsible for knowing their own insurance coverage, since there are multiple insurance plans provided by multiple carriers. If you change insurance during the course of therapy, you must advise the front office personnel on your next visit or by calling 948-2222.

**Medicaid Coverage:** Medicaid coverage is limited to \$1,000 for outpatient services for the period between July 1 to June 30 of each year. We will help you monitor your eligibility and keep you informed as to the best utilization of therapy services. Please remember that we can only monitor what is spent in our clinic, so you will have to inform us of visits to emergency rooms, doctor’s offices, radiology, etc..

**Patients must:**

1. understand that we expect to have the patient/family show support and involvement in the treatment program.
2. be willing to provide accurate information about their medical condition.
3. be willing and able to follow instructions during treatment.
4. be willing to follow department policies and rules.
5. be willing to treat department staff the way that you would want to be treated.

*I hereby acknowledge that I have read and understand the above policies.*

---

Patient/Responsible Party

---

Date