Axis Physical Therapy Inc

Treatment that revolves around the client

Address: 21009 76th Ave West, Edmonds, WA
Phone: (425) 672-2910 Fax: (425) 778-1872
Phone: (425) 245-8548 Fax: (425) 245-8547

Welcome to our office.
Please complete this paperwork to the best of your ability. Feel free to ask any questions.

Patient Information

First Name: _____ M. I. _____ Last Name: _____
Sex: ☐Male ☐Female Birth Date: _____ Social Security: _____
Marital Status: _____ Spouse/Partner Name: _____
Parent/Guardian Name (if applicable): _____
Street Address: _____ Unit: _____
City: _____ State: _____ Zip: _____
Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Not Employed Other: _____
Employer: _____ Occupation: _____

Please list YOUR contact phone numbers in the order in which you wish to be contacted. Checking voicemail and/or text after each number authorizes Axis Physical Therapy to leave confidential voicemails or appointment reminder texts with you, and voicemails with your emergency contacts.

PHONE NUMBER	TYPE OF PHONE	VOICEMAIL OR TEXT?
	☐Home ☐Cell ☐Work	☐Voicemail ☐Text
	☐Home ☐Cell ☐Work	☐Voicemail ☐Text
	☐Home ☐Cell ☐Work	☐Voicemail ☐Text

Axis Physical Therapy may ALSO leave a voice message with:
Name: _____ Relationship to patient: _____
Phone Number: _____

In the case of an emergency Axis Physical Therapy may contact:
Name: _____ Relationship to patient: _____
Phone Number: _____

Please provide an e-mail address to receive any Physiotec exercises:
_____@_____

By signing below you acknowlege your permission for Axis Physical Therapy staff to contact the persons at the phone numbers as you have listed them above.

Patient/Guardian Signature: _____ Date: _____
Printed name if signed on behalf of the patient: _____
Relationship of guardian to patient: _____

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Care Information

Referring Practitioner: _____ Phone: _____
Primary Care Provider: _____ Phone: _____

Workers Compensation and/or Personal Injury Protection:

Claim Manager's Name: _____ Phone: _____
Date of Injury/Accident: _____ Location (State) of Accident: _____
Attorney: _____ Attorney's Phone: _____
Attending Physician on file with L&I: _____

Health Insurance:

Primary Insurance Coverage
Insurance Company: _____
ID/Claim Number: _____ Group Number: _____
Type of Insurance: ☐Commercial ☐Medicare ☐PIP ☐Workers Compensation Other: _____
Subscriber's Full Name: _____
Subscriber's Birthday: _____ Patient's Relationship to Subscriber: _____
Is the subscriber address the same as the patients? ☐Yes ☐No

Secondary Insurance Coverage
Insurance Company: _____
ID/Claim Number: _____ Group Number: _____
Type of Insurance: ☐Commercial ☐Medicare ☐PIP ☐Workers Compensation Other: _____
Subscriber's Full Name: _____
Subscriber's Birthday: _____ Patient's Relationship to Subscriber: _____
Is the subscriber address the same as the patients? ☐Yes ☐No

Tertiary Insurance Coverage
Insurance Company: _____
ID/Claim Number: _____ Group Number: _____
Type of Insurance: ☐Commercial ☐Medicare ☐PIP ☐Workers Compensation Other: _____
Subscriber's Full Name: _____
Subscriber's Birthday: _____ Patient's Relationship to Subscriber: _____
Is the subscriber address the same as the patients? ☐Yes ☐No

Please sign below indicating that the information provided is true and correct to the best of your knowledge.

Patient/Guardian Signature: _____
Print Patient Name: _____ Date: _____

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Current Condition Information

What current condition(s) are you here for today? _____

_____

What is the date of onset or most recent exacerbation of the condition? _____

Cause of injury: _____

What is the most important activity you are here to improve: _____

_____

Has the patient seen any other specialist for this condition before? ☐Yes ☐No If yes, what is the name of the practitioner and date of most recent visit? _____

Please describe previous treatment received related to this condition: _____

_____

Any Imaging? (I.e. MRI, CT, X-Ray) _____

Is the patient in pain today? ☐Yes ☐No What is the patient's dominant hand? ☐Left ☐Right

Use the scale below to indicate the intensity of pain, please write in REST and ACTIVITY if pain varies:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

No Pain — Worst/Most Severe Pain

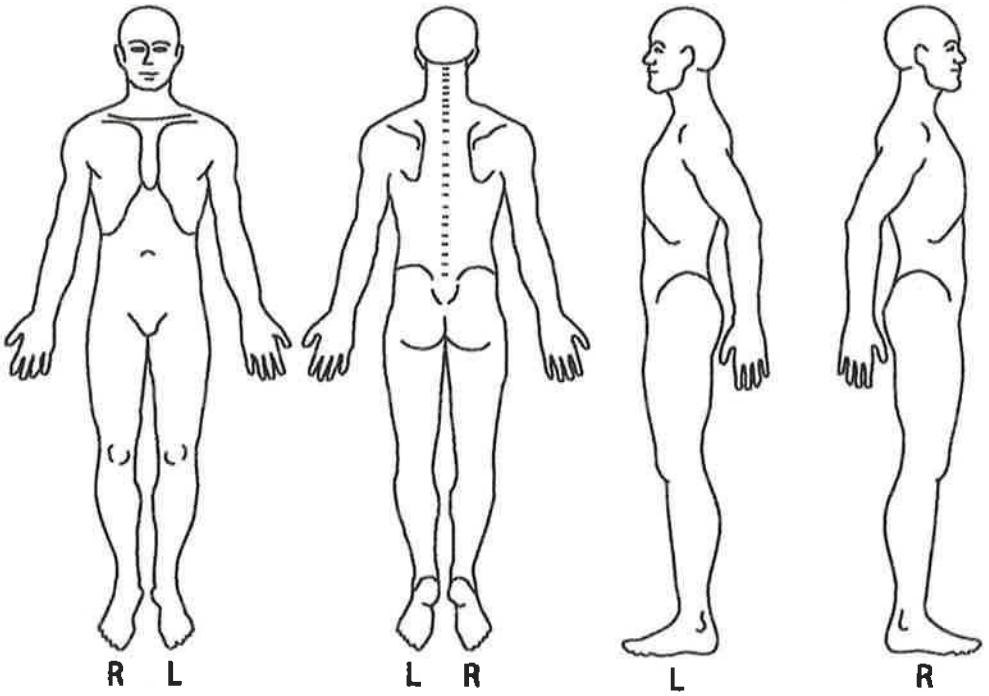
What are the frequency of symptoms? _____

What aggravates the condition? _____

What relieves it? _____

Please use the diagram to indicate what areas of the patient's body will be treated:

What has the pain affected?
☐Mobility
☐Sleep
☐Exercise
☐Relationships
☐Work
☐Social
☐Activity
☐Concentration
☐Appetite
☐Other _____
_____



Print Patient Name: _____

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General Health Information & History

Please check all following therapies the patient has had previously: ☐Physical ☐Aquatic ☐Massage
If yes, please tell us where and when the patient received therapy: _____

_____

Has the patient sustained any injuries related to work or to car accident: ☐Yes ☐No If yes, please describe including dates: _____

_____

_____

Does the patient have any other pertinent medical history? _____

_____

Did the patient have any childhood injuries? _____

_____

Does the patient have any congenital diagnoses? _____

_____

Has the patient sustained any sports injuries in the past? _____

_____

Any additional health history: _____

_____

_____

Date of patient's last physical exam: _____

Please use this box to fill out all surgical history:

Surgery	Date	Any residual issues:

If you need more space, use the back of page and please let us know.

Pregnancy Information

Are you pregnant? ☐Yes ☐No ☐Currently Trying *If No, please skip to Health History.
If yes, how many weeks: _____ Due Date: _____
Are you having any complications and/or concerns with your pregnancy: _____

_____

Any history of complications or miscarriage: _____

_____

Print Patient Name: _____

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General Health Information & History

During the past few months has the patient exhibited any signs of depression? ☐Yes ☐No
Has the patient recently lost interest or pleasure in his or her enjoyed activities? ☐Yes ☐No
How often does the patient exercise: ☐None ☐1-2/week ☐3-4/week ☐5+/week
Types of exercise: _____

_____

Please indicate any current habits the patient exhibits and frequency: (i.e. 4 cigarettes/day)
☐Smoking: _____ ☐Alcohol: _____ ☐Coffee/Soda: _____ ☐Other: _____ : _____
Work Activity: (Select all that apply.) ☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor ☐ _____
Please indicate patient's stress level: ☐Low ☐Moderate ☐High What causes the stress? _____

_____

_____

FAMILY HISTORY: Check all that apply.

	PATIENT	FAMILY		PATIENT	FAMILY
Cancer (type): _____	☐	☐	Asthma	☐	☐
Heart Problems/Cholesterol	☐	☐	Multiple Sclerosis	☐	☐
High Blood Pressure	☐	☐	Hepatitis	☐	☐
Circulation Problems	☐	☐	Kidney Disease	☐	☐
Stroke	☐	☐	Stomach Ulcers	☐	☐
Blood Clots	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Alcoholism	☐	☐
Thyroid Problems	☐	☐	Chemical Dependency	☐	☐
Arthritis (type): _____	☐	☐	Depression	☐	☐
Osteoporosis	☐	☐	Other: _____	☐	☐

CHECK ANY of the following you experience, particulary if it is new or unusual to you.

	PATIENT		PATIENT		PATIENT
Fatigue	☐	Loss of Vision	☐	Difficulty Breathing	☐
Weakness	☐	Eye Redness	☐	Regular Cough	☐
Nausea/Vomiting	☐	Hearing Problems	☐	Arm/Leg Swelling	☐
Fever/Chills/Sweats	☐	Skin Rash	☐	Heart Racing	☐
Dizziness/Light-headedness	☐	Sleeping Problems	☐	Difficulty Swallowing	☐
Numbness or Tingling	☐	Sexual Difficulties	☐	Heartburn/Indigestion	☐
Tremors	☐	Joint/Muscle Swelling	☐	Constipation/Diarrhea	☐
Seizures	☐	Easy Bruising	☐	Blood in Urine/Stool	☐
Double Vision	☐	Excessive Bleeding	☐	Difficulty Urinating	☐

Please sign below indicating that the information provided is true and correct to the best of your knowledge.

Patient/Guardian Signature: _____

Print Patient Name: _____ Date: _____

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Medication Information

Please use this area to provide a list of all medications and supplements the currently used by the patient. If the the patient furnished a separate list, please attach it here. Feel free to use the back of the page for more space.

Medication Name:	Medication Purpose:

Allergy Information

Please use this box to list any and all allergies:

Allergy:	Symptoms (i.e. rash, nasal congestion, constipation)

Print Patient Name: _____

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Consent to Treat & Protected Health Information Policy

This patient and/or guardian consent to the use of disclosure of protected health information by Axis Physical Therapy, Inc. for the purpose of providing treatment, obtaining payment and conducting health care operations. The patient and/or guardian understands that all treatment received from a Physical Therapist, Physical Therapist Assistant may be conditioned upon consent as evidence by signature on this document.
This patient and/or guardian have the right to request a restriction or revoke consent as to how any and all Protected Health Information (PHI) is used or disclosed, in writing, at any time. PHI refers to individually identifiable health information that is transmitted or maintained in any media. This patient and/or guardian have the right to review the Notice of Privacy Practices prior to signing this document. By signing, this patient and/or guardian certifies that the Notice of Privacy Practices has been provided to the patient and/or guardian. The notice provides the types of uses and disclosures of PHI that may occur in treatment, the rights of the patient and the duties of Axis Physical Therapy, Inc. with respect to PHI.
Axis Physical Therapy, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. The patient and/or guardian may obtain a revised copy of any such changes at the time of any following appointment, view the document online or request a copy by mail.

Insurance Payments:
By signing below the patient and/or guardian hereby authorize that insurance payments be paid directly to Axis Physical Therapy, Inc. The patient and/or guardian authorize the release of any information required to process insurance claims. Should any payment for services provided to the patient be made out in the patient's name, the patient and/or guardian gives this office limited power of attorney to endorse any such check for deposit. The patient and/or guardian understands that they are finacially responsible for any remaining balance.
During any treatment at Axis Physical Therapy, Inc. any balance accrued due to deductible and/or co-insurance is payable witin the month upon receipt of statement. If the fianacially responsible party is unable to pay the balance witin the month and fails to establish a payment plan, treatment may be suspended. Axis Physical Therapy, Inc. takes all forms of payment and payments may be made in person, over the phone or by mail. When the patient's treatment is concluded, suspended or terminated, all fees for professional services become immediately due within ninety days. If after ninety days there is no formal payment plan, the account balance is turned over for collection action and the patient/guardian will be responsible for all fees related to efforts in collecting an unpaid account balance. The patient and/or guardian acknowledges that co-payments, not billable to secondary insurance, are due at time of service.

Cancellation Policy:
24 Hour advanced notice is required to cancel any appointments the patient is unable to attend. Any no-show appointment or appointment cancelled with less than 24 hour notice will be subject to an $85.00 fee. This fee is not billable to insurance and will be applied to the patient's account balance. If the patient misses three scheduled appointments without appropriate notification, Axis Physical Therapy, Inc. reserves the right to terminate all future care.

Cash Rate Patients:
Cash rate payments are due at the time of service. If the financially responsible party is unable to make cash rate payments at the time of treatment, it is the party's responsibility to cancel and appointments with at least 24 hours notice. By signing below, the patient and/or guardian acknowledges and agrees to the terms as written above.

Patient/Guardian Signature: _____ **Date:** _____