LINCOLN PHYSICAL THERAPY AND SPORTS REHAB, LLC

FOR RETURNING PATIENTS ONLY

Name ____ Date of Birth ________________ Today's Date ________________

Change in Previous Insurance? Yes ____ No ____

New Insurance ____

New Secondary Insurance ____

Change in address? Yes ____ No ____

New Address ____

Change in Phone Number? Yes ____ No ____

New Phone Number ____ Home or Cell?

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 ____

____

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 ____________________

Office Use Only

Copy of Insurance Card Taken? Yes ____ No ____

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LINCOLN PHYSICAL THERAPY AND SPORTS REHAB, LLC

PHYSICAL THERAPY PATIENT QUESTIONNAIRE

Name ______________________________ **Date of Birth** ______________ **Today's Date** ______________

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? ______________________________

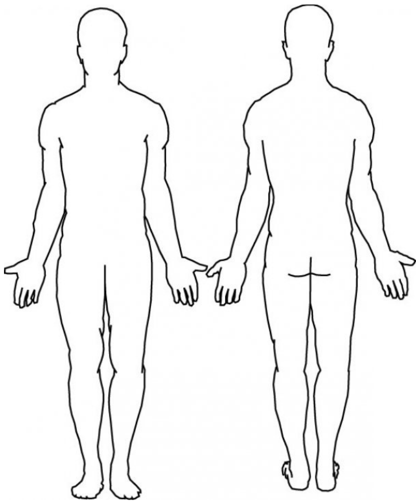
What makes your symptoms worse? ______________________________

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? ______________________________

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