HEALTH ACTIONS PHYSICAL THERAPY
FITNESS • HEALTH • WELLNESS

Patient Information / Subjective Information

Patient Name: _____
Mailing Address: _____
_____
City/State/Zip: _____
Home Phone: _____ Cell Phone: _____
SSN: _____ Sex: _____
Date of Birth: _____ Age: _____
Patient's Employer: _____ _____
Job Title: _____ Job Phone: _____
In case of emergency call: _____
Emergency phone number: _____

Is your condition accident related?
Auto Work Other
How did the accident happen? _____
_____
Date of Accident: _____ Date problem started: _____
# of work days missed: _____
Date of last Doctor's appointment: _____
Date of next Doctor's appointment: _____
Are you currently receiving Home Care? _____

Spouse/Parent Name: _____
Mailing Address: _____
_____
City/State/Zip: _____
Home Phone: _____
SSN: _____ Sex: _____
Date of Birth: _____ Age: _____
Spouse's Employer: _____
Job Title: _____ Job Phone: _____

Email : _____

***** FOR WORKER'S COMP PATIENTS ONLY *****
Worker's Comp Carrier: _____
Address: _____
City/State/Zip: _____
Adjuster: _____
Adjuster's phone: _____
Claim # : _____
Referring Physician: _____
Case Manager:

Primary Insurance Company: _____ **Secondary:** _____

What do you want to achieve with therapy? (your goal) _____
What type of problem has brought you to therapy? _____
When did the problem begin? (date) _____
Have you ever had this problem before? Yes No If yes, when? _____
What type of treatment did you receive? _____ Have you received any Physical Therapy this year? _____
List the Physicians you have seen for this for problem: _____
Have you had any injections for your injury/condition? Yes No When? _____ Did it help? Yes No
Have you had any surgery? Yes No Explain: _____
Have you had any hospital stays related to this problem? Yes No Explain: _____
Are you employed Unemployed Retired Disabled?
If disabled, as of when? _____ Have you received a settlement? Yes No
Has your doctor diagnosed you with Stage One or Stage Two Diabetes? Yes No

Date: _____ Patient's Signature: _____

For Patients returning to Healthactions: I have reviewed all of the above information and made any appropriate changes
Date: _____ Patient's Signature: _____

Consent to Treat and Privacy Notification and Acknowledgement

Patient: _____ Date: _____ DOB: _____
PLEASE PRINT

Consent to Treatment

Consent is hereby given for patient to receive treatment from HealthActions Physical Therapy and Wellness. I understand that risk may be associated with certain procedures, including but not limited to the risks associated with the use of the pool during aquatic therapy.

_____
Initial

I certify that the billing information I have provided is correct. I authorize my insurance carrier to pay all benefits I may be due directly to HealthActions Physical Therapy and Wellness. Authorization is hereby given to release any information that may be necessary to process my insurance claims.

_____
Initial

Rights and Responsibilities

I have received a copy of my patient rights and responsibilities. _____
Initial

Release of Medical Information

I authorize the following persons to have access to my medical information and treatment.

Spouse: _____
Family: _____
Other: _____

Privacy Notice

I have received the privacy notice for HealthActions _____
Initial

I agree that during the course of treatment my case may be discussed during weekly professional staff meetings for quality of care purposes. I agree to notifications and appointment reminders at my home address and phone number or this alternate phone number: _____ _____
Initial

I have read, initialed, and understand the content of this form.

_____ _____ _____ _____
Patient Signature Date Witness Date

To be completed by HealthActions Physical Therapy and Wellness employee only if acknowledgement is refused.

After a good faith attempt to obtain this Acknowledgement, the patient or his/her representative refused or was unable to acknowledge receipt of our Privacy Notice for the following reason(s):

_____

_____

_____ _____
Signature of Employee Date

HEALTH ACTIONS
PHYSICAL THERAPY
FITNESS • HEALTH • WELLNESS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name:_____ Date of Birth:_____

I hereby authorize and request:

_____(Releasor)
Name of Facility/Hospital

_____
Address
_____

To release to:

Health*Actions* Physical Therapy and Wellness (Releasee)
(circle your location)

JACKSON	GROVE HILL	THOMASVILLE	MONROEVILLE	TROY	DOTHAN-FLOWERS
P: 251-246-5761	P: 251-275-4905	P: 334-636-1461	P: 251-575-1933	P: 334-670-5435	P: 334-615-8440
F: 251-246-3779	F: 251-275-7906	F: 334-636-1463	F: 251-575-2807	F: 334-670-5234	F: 334-615-8442

A copy of the medical records on the above named patient pertaining to:

_____Outpatient care, date_____

_____Hospitalization, date(s)_____

I acknowledge that data to be released may include material that is protected by Federal Law such as mental, drug and/or alcohol, HIV information. My signature below authorizes release to same. I understand this authorization is valid for 90 days and may be revoked by me at any time.

_____ _____
Signature (Patient) Date

_____ _____
Witness Date

Releasor, its agents and employees are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information.

HealthActions P.A.

Medical History

Date:

Name: _____DOB:_____Age:_____ Height/Weight:_____

Please fill in the blanks and check any box that applies to you.

Coronary Artery Disease Risk Factors:

- ☐ Male > 45 yrs of age
- ☐ Female > 55 yrs of age
- ☐ Diabetes Mellitus
- ☐ Obesity
- ☐ Sedentary lifestyle & job
- ☐ Smoking
- ☐ High Blood Pressure (>140/90 or on meds)
- ☐ High cholesterol (>200mg/dl)
- ☐ Family Hx of Coronary Artery Disease (father/brother had a heart attack by age 55, mother/sister had a heart attack by age 65)

Major Signs/Symptoms:

- ☐ Pain/discomfort in chest, neck, jaw or arms
- ☐ Shortness of breath at rest or mild exertion
- ☐ Dizziness, light-headed, or fainting
- ☐ Known heart murmur
- ☐ Ankle swelling
- ☐ Rapid or skipped heart beat
- ☐ UNUSUAL fatigue w/ USUAL activities
- ☐ Orthopnea/Nocturnal Dyspnea (difficulty breathing at night or when lying down)
- ☐ Orthopedic limitations (foot, back, neck, knee, hip, hand, wrist, shoulder problems, broken bones, limited range of motion in joints, arthritis,bursitis)
- ☐ Intermittent Claudication (pain in calf with walking/activity)

Cardiopulmonary/Metabolic Disease:

- ☐ Heart Attack
- ☐ Angioplasty
- ☐ Coronary Artery Bypass Grafting
- ☐ COPD (Lung Disease)
- ☐ Diabetes Mellitus
- ☐ Stable Angina
- ☐ Congestive Heart Failure
- ☐ Peripheral vascular disease
- ☐ Hospitalized within past 6 mos? _____
- ☐ Pacemaker

Other: Please check if currently or previously diagnosed with the following.

- ☐ Phlebitis or emboli _____
- ☐ Rheumatic fever _____
- ☐ Fibromyalgia _____
- ☐ Low Blood Pressure _____
- ☐ Trouble Sleeping _____
- ☐ Migraine/Recurrent Headaches _____
- ☐ Epilepsy or Seizures _____
- ☐ Anemia _____
- ☐ Cancer _____
- ☐ Hernia _____
- ☐ Tuberculosis _____
- ☐ Allergies _____
- ☐ Asthma _____
- ☐ Emphysema _____
- ☐ Bronchitis _____
- ☐ Pneumonia _____
- ☐ ↑ anxiety or depression _____
- ☐ Emotional disorders _____
- ☐ Ulcers _____
- ☐ Stomach or intestinal problems _____
- ☐ Hepatitis _____
- ☐ Eating Disorder _____
- ☐ Osteoporosis: _____
- ☐ Other: _____

MEDICATIONS WITH DOSAGE
(include all Prescriptions/vitamins/herbs/over-the counter)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you had any surgery?____Yes ____No
What type of surgery did you have?_____

_____

Have you had any hospital stays?____Yes ____No

When?_____

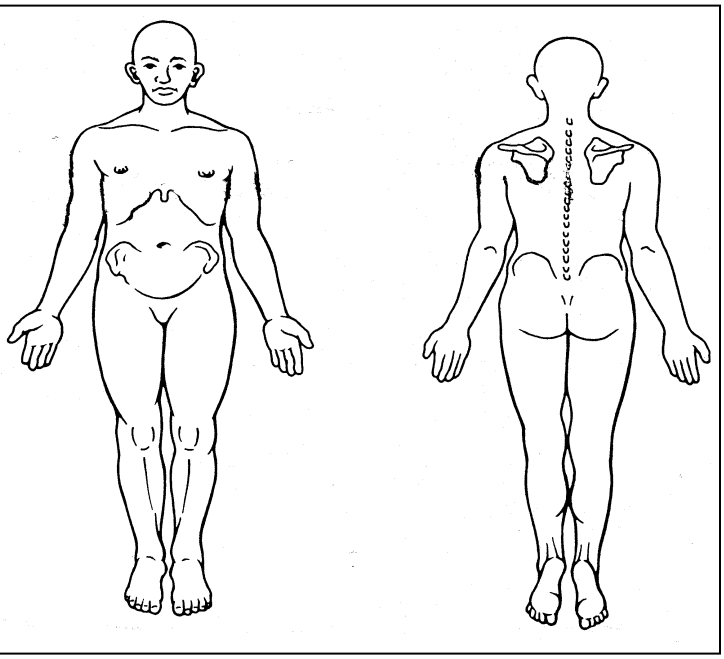
Signature:_____ **Date** **Signature of Parent/Guardian:**_____ **(if under 19)** **Date**

Witness: _____ **Date**

PAIN INFORMATION

Name:_____

Please mark the areas where you have pain, numbness, or tingling. *P = Pain N = Numbness T = Tingling*



Pain level today. *(please circle)*

1 2 3 4 5 6 7 8 9 10

(least pain ----------greatest pain)

What makes your pain less?

_____

What makes your pain worse?

_____

Is pain □better or □worse in the morning?

Is pain □better or □worse in the afternoon?

JOB INFORMATION

Job Physical Demands	Constantly 2/3-Full Day	Frequently 1/3-2/3 of Day	Occasionally Up to 1/3 Day	Never	Match
Floor to Waist Lift	lbs	lbs	lbs		
Waist to Eye Level Lift	lbs	lbs	lbs		
Two Handed Carrying	lbs	lbs	lbs		
One Handed Carrying	lbs	lbs	lbs		
Pushing	lbs	lbs	lbs		
Pulling	lbs	lbs	lbs		
Sitting					
Standing					
Work Arms Over Head Standing					
Work Bent over Standing/Stooping					
Work Kneeling					
Work Bent Over Sitting					
Work Squatting/Crouching					
Work Arms Over Head Supine					
Climbing Stairs					
Repetitive Squatting					
Walking					
Crawling					
Climbing a Ladder					
Repetitive Trunk Rotation-Standing					
Repetitive Trunk Rotation-Sitting					

WHO is your employer? _____

WHAT is your job title/responsibility?_____

ARE you currently working? □ **Yes** □ **No** **If yes, how much?** □ **Full Duty** □ **Restricted Duty**

Hours for typical work week? _____ **How many TOTAL work days have you missed?** _____

What work duties/tasks have been stopped/limited by your injury/condition? _____