

**PHYSICAL THERAPY INITIAL EVALUATION FORM**

**PATIENT INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE INITIAL)

SOCIAL SECURITY NUMBER \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_ HEIGHT \_\_\_\_ WEIGHT \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL ( ) \_\_\_\_\_ - \_\_\_\_\_ EMAIL \_\_\_\_\_

ARE YOU CURRENTLY WORKING YES  NO

**EMERGENCY CONTACT INFORMATION**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE # \_\_\_\_\_

**REHAB INFORMATION**

1. CHIEF COMPLAINT/ AILMENT/ INJURY \_\_\_\_\_

2. DATE OF INJURY \_\_\_\_\_ DATE OF SURGERY \_\_\_\_\_

3. BRIEFLY DESCRIBE YOUR INJURY, AND HOW IT BEGAN \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. HAVE YOU RECEIVED THERAPY FOR THIS CONDITION?  YES  NO WHEN? \_\_\_\_\_

5. HAS YOUR CONDITION BEEN GETTING: WORSE  SAME  BETTER

6. ARE YOUR SYMPTOMS: CONSTANT  INTERMITTENT

7. CIRCLE THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

AT BEST: 0 1 2 3 4 5 6 7 8 9 10

AT WORST: 0 1 2 3 4 5 6 7 8 9 10

8. WHAT **DECREASES**/ MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

- BENDING                       MOVEMENT                       REST                       BETTER IN AM
- SITTING                       STANDING                       HEAT                       BETTER AS DAY PROGRESSES
- RISING                       WALKING                       ICE                       BETTER IN PM
- CHANGING POSITIONS     LYING                       MEDICATION
- N/A CAST JUST REMOVED

**MEDICAL INFORMATION**

(MARK ALL THAT APPLY) \*THIS INFORMATION IS CONFIDENTIAL AND REMAINS PART OF YOUR CHART.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> DIFFICULTY SWALLOWING    | <input type="checkbox"/> MOTION SICKNESS         | <input type="checkbox"/> STROKE            |
| <input type="checkbox"/> ARTHRITIS                | <input type="checkbox"/> FEVER/CHILLS/SWEATS     | <input type="checkbox"/> OSTEOPOROSIS      |
| <input type="checkbox"/> HIGH BLOOD PRESSURE      | <input type="checkbox"/> UNEXPLAINED WEIGHT LOSS | <input type="checkbox"/> ANEMIA            |
| <input type="checkbox"/> HEART TROUBLE            | <input type="checkbox"/> BLOOD CLOTS             | <input type="checkbox"/> BLEEDING PROBLEMS |
| <input type="checkbox"/> PACEMAKER                | <input type="checkbox"/> SHORTNESS OF BREATH     | <input type="checkbox"/> HIV/ HEPATITIS    |
| <input type="checkbox"/> EPILEPSY/ SEIZURES       | <input type="checkbox"/> HISTORY OF SMOKING      | <input type="checkbox"/> DIABETES          |
| <input type="checkbox"/> HISTORY OF DRUG ABUSE    | <input type="checkbox"/> DEPRESSION/ ANXIETY     | <input type="checkbox"/> MYOFASCIAL PAIN   |
| <input type="checkbox"/> FIBROMYALGIA             | <input type="checkbox"/> PREGNANCY               | <input type="checkbox"/> CANCER            |
| <input type="checkbox"/> HISTORY OF ALCOHOL ABUSE | <input type="checkbox"/> AUTO IMMUNE DISEASES    | <input type="checkbox"/> ASTHMA            |
| <input type="checkbox"/> CHRONIC HEADACHES        | <input type="checkbox"/> LOW BLOOD PRESSURE      | <input type="checkbox"/> SLEEPING TROUBLE  |
| <input type="checkbox"/> LOW BLOOD SUGAR          | <input type="checkbox"/> TMJ PROBLEMS            | <input type="checkbox"/> ULCERS            |

12. PREVIOUS SURGERIES: \_\_\_\_\_

13. PLEASE LIST **ALL** MEDICATIONS YOU ARE CURRENTLY TAKING: \_\_\_\_\_

14. ALLERGIES: \_\_\_\_\_

15. WHAT LIMITATIONS DO YOU HAVE DUE TO THIS INJURY? (FOR EXAMPLE: WORKING, HOUSE HOLD CHORES, ETC...) \_\_\_\_\_

15. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY? \_\_\_\_\_

## Cancelation and Co-pay Policy

### Cancelations

Welcome to Ypsilanti Rehabilitation Services. We appreciate you choosing us for your physical therapy needs.

We strive to accomplish the best possible results and success for you. To accomplish this, we will need your help. We ask that you attend as prescribed by your physician and communicate with the therapist or patient representative if this does not work for you. If you have any questions or concerns about your treatment, we appreciate you letting us know.

We require a 24-hour notice if you need to cancel or reschedule an appointment. We understand you may become ill or have an emergency and need to cancel a same day appointment, at the time you cancel we will reschedule your appointment.

Thank you for your cooperation and we look forward to helping you meet your physical therapy goals.

### Deductibles, Coinsurance and Copays

With all the changes in the insurance industry you may have a deductible, coinsurance and/ or copay. We ask that you give us all your insurance information so we will be able to bill properly. Deductibles and coinsurance will be billed to you once we receive payment. Copays must be made at time of appointment. Exceptions to this must be approved by patient representative.

Your insurance deems you have a deductible of \$ \_\_\_\_\_, a coinsurance of \_\_\_\_\_ and/or a co-pay of \$ \_\_\_\_\_.

Your Ypsi Rehab Staff.

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

By signing below:

I understand that as part of this organization’s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**MEDICARE PATIENTS PLEASE NOTE**

**You have a cap of \$1980 for the calendar year. This includes Physical Therapy, Speech Therapy, Chiropractic, Some Pain Clinics, etc. If you go over your cap the non covered charges are your responsibility.**

**NON MEDICARE PATIENTS**

Ypsilanti Rehabilitation Services is working to make your physical therapy experience the best from your first visit until your account is paid in full. By signing below you are indicating that you fully understand your insurance coverage. This means that you are responsible for any deductible, co-pay, co-insurance, and/or any non-covered or denied charges your insurance may deem your responsibility. Also, that you agree to pay Ypsi Rehab within 30 days of receiving your bill.

Signed \_\_\_\_\_ Date \_\_\_\_\_

I **DO** authorize Ypsilanti Rehabilitation Services, Inc. to discuss my treatment or billing with the indicated persons:

	Treatment		Billing
Spouse	_____	Spouse	_____
Child	_____	Child	_____
Other	_____	Other	_____
Other	_____	Other	_____

Further I permit a copy of this authorization to be used in place of the original, and I request payment of medical insurance benefits to Ypsilanti Rehabilitation Services, Inc. I also authorize Ypsilanti Rehabilitation Services, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signed \_\_\_\_\_ Date \_\_\_\_\_

If not signed by the patient, indicate relationship to patient (e.g. parent)

Relationship \_\_\_\_\_ Witnessed By \_\_\_\_\_



**New Patient Consent to the Use and Disclosure of Health Information  
for Treatment, Payment, or Healthcare Operations**

I, \_\_\_\_\_, understand that as part of my health care, Ypsilanti Rehabilitation Services, Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Ypsilanti Rehabilitation Services, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Ypsilanti Rehabilitation Services, Inc. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Ypsilanti Rehabilitation Services, Inc. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

Initials \_\_\_\_\_

2063 Rawsonville Rd.  
Belleville, MI 48111

**Phone** 734.485.4544  
**Fax** 734.485.8125

*www.ypsirehab.com*

9. WHAT **INCREASES**/ MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

- |  |  |                                      |  |
|--|--|--------------------------------------|--|
| <input type="checkbox"/> BENDING                 | <input type="checkbox"/> MOVEMENT              | <input type="checkbox"/> REST        | <input type="checkbox"/> SNEEZE                |
| <input type="checkbox"/> SITTING                 | <input type="checkbox"/> STANDING              | <input type="checkbox"/> STAIRS      | <input type="checkbox"/> DEEP BREATH           |
| <input type="checkbox"/> RISING                  | <input type="checkbox"/> WALKING               | <input type="checkbox"/> COUGH       | <input type="checkbox"/> MEDICATION            |
| <input type="checkbox"/> LYING                   | <input type="checkbox"/> WORSE IN AM           | <input type="checkbox"/> WORSE IN PM | <input type="checkbox"/> PROLONGED POSITIONING |
| <input type="checkbox"/> WORSE AS DAY PROGRESSES | <input type="checkbox"/> N/A CAST JUST REMOVED |                                      |  |

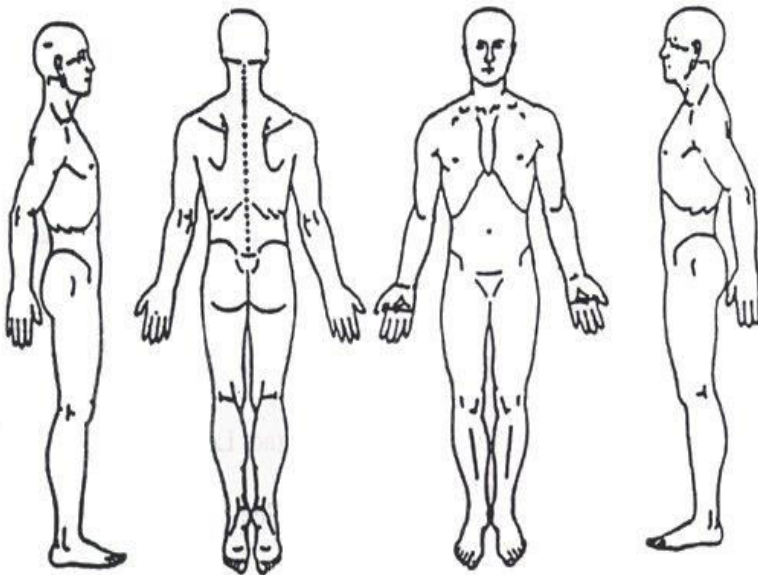
10. PREVIOUS MEDICAL INTERVENTION (MARK ALL THAT APPLY)

- X-RAY       CATSCAN       INJECTIONS      OTHER \_\_\_\_\_

11. HAVE YOU EVER BEEN TO A PAIN CLINIC?    YES     NO

IF YES, WHERE AND WHAT FOR \_\_\_\_\_

**DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS.**



- SEVERE PAIN                      \*\*
- MODERATE PAIN                 00
- DULL ACHE                        ##
- NUMBMESS/TINGLING         !!
- USE ARROWS TO INDICATE  
RADIATING PAIN

Injury Date \_\_\_\_\_

**FOR OFFICE USE ONLY**

Flexion				Flexors	
Extension				Extensors	
Side Flexion				Hip Flexor	
SLR				Hip Extensor	
				Quads	
				Hamstrings	
				Feet DF/PF	