Patient #_____

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 CURRENTY 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.

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

Ypsi Rehab
Ypsilanti Rehabilitation Services, Inc.
Physical Therapy
Personal and Professional
Since 1982

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)

☐ BENDING ☐ MOVEMENT ☐ REST ☐ SNEEZE

☐ SITTING ☐ STANDING ☐ STAIRS ☐ DEEP BREATH

☐ RISING ☐ WALKING ☐ COUGH ☐ MEDICATION

☐ LYING ☐ WORSE IN AM ☐ WORSE IN PM ☐ PROLONGED POSITIONING

☐ WORSE AS DAY PROGRESSES ☐ N/A CAST JUST REMOVED

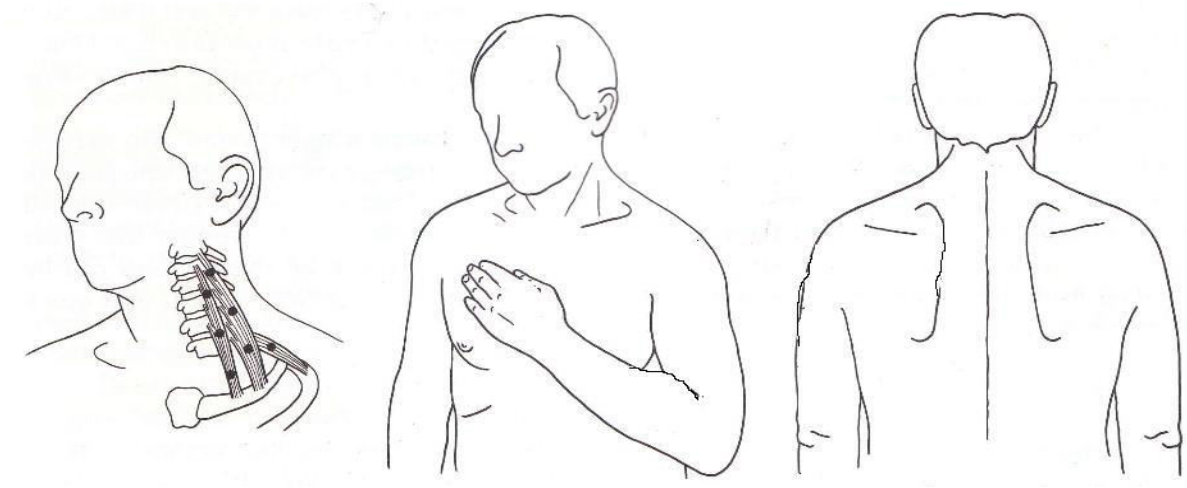
10. PREVIOUS MEDICAL INTERVENTION (MARK ALL THAT APPLY)

☐ 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	
Abduction				Abductors	
Internal Rotation				Internal Rotation	
External Rotation				External Rotation	
Extension				Extensors	
Horizontal Abduction					