INSPIRE
PHYSICAL & HAND THERAPY

Welcome!

We appreciate you choosing our clinic! Our mission is to provide you expert and personalized care with exceptional customer service.

Our goal is to be your first and best option to stay active and live pain-free. As an established patient at our clinic, you have unlimited access to your provider via email both during AND after your care is completed. We also offer complimentary injury screenings for you and your family.

Your feedback is important. Please ask questions along the way, and we look forward to earning your trust.

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Patient information

Last Name _____ First Name _____ MI _____

Mailing Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone (_____) _____-_____Cell (_____) _____-_____ Work (____) _____- _____

Date of Birth ____/____/_____ SSN _____ Gender _____ Marital Status _____

How did you hear about us? (check the box that best applies) ❒ Referred by Doctor ❒ Saw Advertisement ❒ Past Patient ❒ Recommended by family/friend ❒ Internet Search (Google) ❒ Social Media (Facebook)

Emergency Contact

Last Name _____ First Name _____

Relationship_____ Phone(_____)_____ _____

Employer

Name _____ Phone(_____)_____

Mailing Address _____

City _____ State _____ Zip _____

Insurance Subscriber (If other than patient) Name and DOB:_____

Appointment Reminder Preference (Circle One): Text Phone Email

(If Applicable) Date of Injury:_____Date of Surgery:_____

Authorization to treat, release information and assignment of insurance benefits

I hereby authorize Inspire Physical & Hand Therapy to evaluate and treat me (or my dependent). I authorize Inspire Physical & Hand Therapy to release to my insurance company(ies) any medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to the providers at Inspire Physical & Hand Therapy. I hereby agree to full responsibility for all expenses incurred by myself, or minor child.

Financial policy and agreement

1. Insurance co-payments are required at check-in. We accept most major credit cards, cash and check.
2. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and any changes to your insurance. Your bill is your responsibility, whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claims. You are responsible for knowing what your insurance does or does not cover and the providers and network(s) covered by your insurance company. You will be billed for any service provided, but not covered by your insurance company.

Notice of privacy practices acknowledgement (HIPAA)

We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information.

Other parties whom you would like to receive information on your behalf (not insurance companies):

_____ _____

No-show/Late cancellation policy

AT INSPIRE PHYSICAL & HAND THERAPY, WE VALUE OUR TIME WITH OUR PATIENTS AND BELIEVE THAT KEEPING YOUR APPOINTMENT IS AN INTEGRAL PORTION OF YOUR RECOVERY. PLEASE BE ADVISED, A MINIMUM OF 24 HOURS' NOTICE IS REQUIRED IF YOU NEED TO CANCEL AN APPOINTMENT. IF YOU NO-SHOW OR CANCEL WITHOUT SUFFICIENT NOTICE TWICE, YOU WILL BE PLACED ON A SAME-DAY CALL IN BASIS. THIS MEANS YOU WILL HAVE TO CALL IN THE MORNING FOR AN APPOINTMENT THAT DAY. WE MAY NOT BE ABLE TO ACCOMMODATE ALL SAME-DAY CALL IN REQUESTS. Initials_____

Message authorization

I authorize IPHT to leave detailed information on my phone: Cell: Y / N Home: Y / N

Initials: _____

I have read and acknowledge the above statements with my signature below.

Signature: _____ Date: _____

INSPIRE PHYSICAL & HAND THERAPY

MEDICAL QUESTIONNAIRE

Medical Questionnaire

Patient Name:_____ Date_____ Date of Birth_____Age____

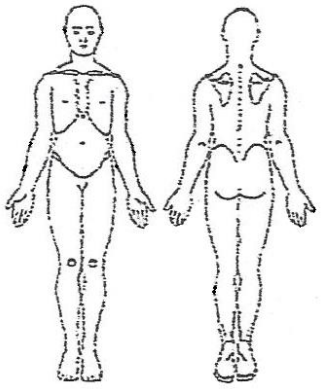
Occupation:_____ Employer:_____ Hrs/Wk_____

What problem or diagnosis brings you here today?_____

Side of Injury: ◯ R ◯ L Date of Injury?_____ Who referred you to PT?_____

Briefly describe your symptoms:_____

Describe how your condition or injury occurred:_____



⇦ Shade your areas of pain or discomfort on the figures to the left:

Please rate your pain on the scale below from 0 to 10:
(0=no pain; 10=worst pain imaginable/emergency room pain)

Pain at rest: ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Pain with activity: ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

What is the frequency of your pain? ◯Constant ◯Intermittent

Does your pain wake you at night? ◯Y ◯N

How many times?_____

What eases your symptoms?_____

What aggravates your symptoms?_____

Are your symptoms getting ◯Better ◯Worse ◯Same Is your pain worse in the ◯AM ◯PM ◯Mid-Day

Are you currently working? ◯Y ◯N Are you currently on: ◯ Light duty ◯ Normal Duty

Is this a Motor Vehicle claim? ◯Y ◯N

What activities at home, work or recreational are you unable to perform?_____

Have you had a similar condition before? ◯ Y ◯N If yes, when_____

Have you had tests for this condition? ◯ Y ◯N If yes, results:_____

CIRCLE tests: X-Rays MRI Bone Scan CT Scan Nerve Tests Blood Tests Other_____

Have you had any other treatment for this condition? ◯Y ◯N

If yes, what Kind? ◯PT ◯OT ◯Chiropractic ◯Massage

CIRCLE Current Level of Physical Activity: ◯ High ◯Medium ◯Low List:_____

What goals do you hope to accomplish with Physical Therapy?_____

Medical History (Check all that apply)

☐ Angina/Chest Pain	☐ Cancer	☐ Hearing Problems	☐ Osteoporosis
☐ Asthma	☐ Depression	☐ Heart Disease	☐ Pacemaker/Nitroglycerin
☐ Arthritis	☐ Diabetes	☐ Hepatitis	☐ Poor Circulation/Raynaud's
☐ Blackouts	☐ Diverticulitis	☐ High Blood Pressure	☐ Polio
☐ Blindness	☐ Ear Infections	☐ High Cholesterol	☐ Seizures
☐ Blood Clot	☐ Endometriosis	☐ Hypoglycemia	☐ Stroke
☐ Bowel or Bladder Problems	☐ Fibroids	☐ Menopause	☐ TB
☐ Carpel Tunnel Syndrome	☐ Fibromyalgia	☐ Migraine Headaches	☐ Traumatic Injury/MVA
☐ Chest/Abdominal Surgery	☐ Fractures	☐ Major spinal issues	☐ Other
☐ Coronary Artery Disease	☐ Frequent Falls	☐ MRSA	

Are you Pregnant? ◯Y ◯N

Do you have a history of whiplash or low back pain? ◯ Y ◯N If so, when/how long?_____

Do you smoke tobacco? ◯ Y ◯ N If yes, how much?_____ How long?_____

Medications/Allergies/Surgeries

List current medications:_____

List current allergies:_____

List all surgeries:_____

Signature_____ **Date**_____