



Last Name _____ First _____ MI _____
Address _____ City _____ State _____ Zip _____
Home Ph# _____ Cell Ph# _____ Work Ph# _____
Birth date _____ Sex M F Marital Status S M D W Calif. ID# _____
Email Address _____
Employer _____ Title _____ SS# _____
Address _____ City _____ State _____ Zip _____
Referring Dr. _____ Ph# _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Injury _____ Diagnosis: _____
Cause of injury/ complaint Auto Work Other
Detail of Injury: _____

*******INSURANCE INFORMATION*******

Primary Health Insurance Company _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Insured's name _____ DOB _____ Employer _____
Insurance ID # _____ Group # _____ Co-pay _____

Secondary Health Insurance Company _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Insurance ID # _____ Group # _____
Insured's Name _____ Insured's DOB _____
Relation _____ Insured's Employer _____

***** PLEASE FILL THIS SECTION IF YOU HAVE BEEN IN AN AUTO ACCIDENT*****

Auto Insurance company _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Claim # _____ Adjuster _____ Med pay Available? Y N
Address _____ Relation _____
3rd Party Insurance _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Claim # _____ Adjuster _____ Med Pay available? Y N
Attorney _____ Phone # _____
Address _____ City _____ State _____ Zip _____

Patient's Signature: _____ **Date:** _____

Patient's History of Current Injury/Illness

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Sex: _____ Marital Status _____ # Children _____ Ages _____

Occupation: _____ R-handed _____ L-handed _____ Ht. _____ Wt. _____

Have you ever been a patient here before? Yes _____ No _____; If yes, for the _____ same or _____ different problem?

Please indicate for which body region you are seeking treatment:

__ Neck __ Mid Back __ Low Back __ Shoulder __ Elbow __ Hand/wrist __ Hip __ Knee __ Ankle/foot __ Other

When did your symptoms start? Date _____ Can you identify a cause for your symptoms? Yes _____ No _____

If yes, specify: _____

Have you ever had similar symptoms in the past? Yes _____ No _____ If yes, when? _____

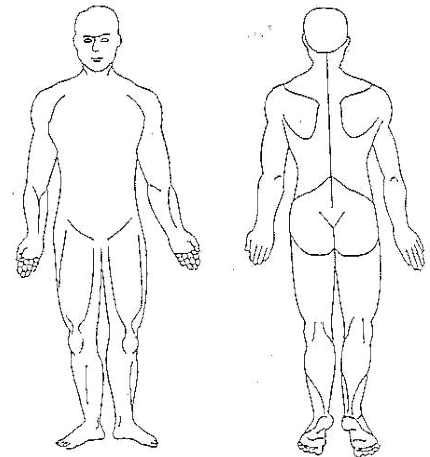
Have you recently had the following tests? Yes _____ No _____ If yes, check all that apply:

____ x-rays ____ Bone Scan ____ Myelogram ____ EKG
____ CT Scan ____ EMG ____ Stress Test ____ Echocardiogram
____ MRI ____ Blood Tests ____ Pulmonary Function Test ____ Other (Please list) _____

Pain rating: Indicate your average level of pain by circling the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10
Pain free Unconscious
Pain

Describe the character of your pain? (What does it feel like...sharp, dull, achy, etc.?)



Is the pain there all the time (constant)? Yes _____ No _____

Does the pain move or radiate anywhere? Yes _____ No _____

If yes, describe location of radiation or numbness

Do you have numbness, tingling, or weakness? Yes _____ No _____

If yes, please describe: _____

Please use the body diagram above and *Shade*

Areas of Pain

Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms? Yes _____ No _____

Describe _____

What activities/positions make your pain worse? _____

What activities/positions make your pain better? _____

Patient's History of Current Injury/Illness

Patient's Name: _____

Date: _____

Have you previously seen any other health care provider for this problem? ___ Yes ___ No

___ Physician ___ Osteopath ___ Podiatrist ___ Other (Please list below)
 ___ Physical Therapist ___ Chiropractor ___ Dentist _____

Are you currently seeing any other health care provider for this condition? ___ Yes ___ No; If Yes, please list: _____

Have you been discharged from the hospital, a skilled nursing facility, or Home Health Agency in the past 30 days related to this condition? Yes ___ No ___ If yes, please describe: _____

Please circle those treatments listed below that have been tried in the past:

___ Physical Therapy ___ Chiropractic ___ Acupuncture ___ Braces ___ Collars ___ Tens Unit ___ Injections
 ___ Medications ___ None ___ Other (please describe): _____

RATING SCALE: For each activity listed below, please rate your ability using the ability scale (or mark not-applicable) and pain level (if any) using the pain scale (0-10) on the previous page:

1- Able to do without difficulty	2- Able to do with little difficulty	3- Able to do with moderate difficulty	4- Able to do with much difficulty	5- Unable to do
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Activity/Function/Skill	Ability	Pain Level	Prior Level of Function (Before Illness/Injury)	N/A
Rolling over in bed				
Transfer to/from bed				
Transfer to/from bath				
Bathing				
Dressing				
Grooming				
Balancing				
Sitting				
Kneeling				
Stooping/squatting/bendin				
Standing				
Walking				
Stair climbing				
Lifting				
Reaching- level/overhead				
Carrying				
Transfer to/from car				
Driving				
Using telephone				
Meal preparation				
Household cleaning				
List Other Activities Affected by your symptoms (i.e. sports, hobbies, etc.)				



Patient's Name: _____ Date: _____

Describe ANY and ALL treatments you have had in the past for this injury (including name of doctors, Physical Therapists, Acupuncturists, Chiropractors): _____

If yes, what kind of treatment? _____
Dates treatment received: _____ How many sessions: _____

Did treatment from any of the above-mentioned professionals help? Yes No

List dates and descriptions of ANY and ALL other accidents, illnesses or injuries you have had in the past that can affect your current symptoms: _____

Do you have any other health conditions i.e. **Pacemakers**, fractures, **pregnancy** and implants: _____

Have you been recently diagnosed with **Tumor** and/or **Cancer**: Yes: _____ No: _____
If in the past if you have been diagnosed with Tumor and/or Cancer, how long have you been Tumor/Cancer free: _____

If Auto accident:

Were you at fault?	Yes	No
Were you wearing a seatbelt?	Yes	No
What part of your car is damaged?	_____	
What is the total cost of repair?	_____	
Was a police report filed?	Yes	No

I certify that the statements are true and correct to the best of my knowledge. I hereby assign my insurance benefits to be paid ONLY and DIRECTLY to Pleasanton Physical Therapy Services, Inc./Back on Track PT. I authorize Pleasanton Physical Therapy Services, Inc./Back on Track PT to release information necessary to process my claims. I give consent to Pleasanton Physical Therapy Services, Inc./Back on Track PT to provide Physical Therapy treatments to me as prescribed by my physician. I grant Hiten Dave' RPT a lien on any money due to me by way of legal action that may arise from this claim for payment of services rendered.

Signature of Patient/Guardian if minor

Date



PAYMENT POLICY

As a courtesy, we will bill your insurance carrier for service rendered. You are responsible for all co- payments, your deductible and any amounts determined by your insurance plan, as not deemed medically necessary. Patients should remember that service rendered by our company is rendered to the patient, and not to the insurance carrier. Payment is due at time of service. We will accept cash, personal check, or credit card.

We value you, our patients, and will continue to provide you with the best physical therapy possible. Should you have any questions regarding the above payment policy, please contact our Billing department at (925) 426-6986.

CONSENT FOR TREATMENT

I consent to have Back On Track Physical Therapy/ Pleasanton Physical Therapy to provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at anytime.

ASSIGNMENT OF MEDICAL BENEFITS

I hereby authorize the release of any medical records and medical, including statements of my account pertinent to this injury or illness, which are necessary to process this claim.

AUTHORIZATION TO LEAVE MESSAGES

I hereby authorize Back On Track Physical Therapy/Pleasanton Physical Therapy to leave detailed information on my answering machine, voice mail or to someone who may answer at my home phone number regarding my missed or upcoming appointments.

24 HOUR CANCELLATION POLICY

There will be a \$45.00 charge for all appointments that are not cancelled or rescheduled in 24 hours in advance.

Patient, Insured or Authorized agent's signature

Date



Patient Consent to use and Disclosure of Health Information for Treatment, Payment, or Healthcare operations

I, _____ understand that as part of my healthcare, Pleasanton Physical Therapy/Back On Track Physical Therapy originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for care or treatment, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A tool for routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices 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 object to the use of my health information for directory purposes, and
- 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 Pleasanton Physical Therapy/Back On Track Physical Therapy 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 taken action I 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 Pleasanton Physical Therapy/Back On Track Physical Therapy reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Federal Regulations. Should Pleasanton Physical Therapy change their notice, they will send a copy of any revised notice to the address I have provided.

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

I understand that as a 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.

Patient's signature

Date