MOVEMENTPLUS
PHYSICAL THERAPY

94-216 Farrington Hwy. Suite A102
Waipahu, HI 96797
(808) 600-9148

PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Email Address:			
Birth Date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	

Chose Clinic Because/ Referred to Clinic by Dr.: ☐ Insurance Plan ☐ Word of Mouth:

☐ I am a Former Patient ☐ Close to Work/Home ☐ Web Search/Website ☐ Drive-by ☐ Advertisement

WORK INFORMATION

Employer:	Work Phone: ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION

Referring Dr:	Phone: ( ) -
Regular Dr./PCP	Phone: ( ) -

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:		
Subscriber's Name (If different):		Birth Date: / /
ID. #:	Group/Policy #:	Policy Holder's SSN:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Name of Secondary Insurance:		
Subscriber's Name:		Birth Date: / /
ID. #:	Group/Policy #	
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

AUTO OR WORK INJURY CLAIM

(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: ☐ Auto:	☐ Labor & Industries:		
Adjuster/Claim Manager:		Phone:	Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

IN CASE OF EMERGENCY

Name of Local Relative or Friend:		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -
Please provide the name of the person(s) to whom Weiss Physical Therapy Associates, P.C. may disclose health information		
Name:	Relationship to Patient:	Phone: ( ) -
May we send an email or leave messages regarding appointments or treatment on your answering machine? ☐ Yes ☐ No		

I have read and agree to the above, including the authorization to disclose my health information to the named recipient(s). Additionally, I authorize my insurance benefits be paid directly to MovementPlus Physical Therapy and authorize said practice to release any information required to process my claim. I understand that I am financially responsible for any remaining balance.

PATIENT /GUARDIAN SIGNATURE DATE

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PAST MEDICAL HISTORY FORM **Patient Name** _____

BLOOD PRESSURE	YES	NO
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Arrhythmia(s)	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker?	☐	☐

MUSCLE CONDITION	YES	NO
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Muscular Dystrophy	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐
Rheumatoid Arthritis	☐	☐
Osteoarthritis	☐	☐

OTHER CONDITIONS	YES	NO
Carpal Tunnel R/L	☐	☐
Parkinson's Disease	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐
High Cholesterol	☐	☐
Osteoporosis	☐	☐
Anxiety	☐	☐
Cancer	☐	☐
Depression	☐	☐
Stroke	☐	☐
Thyroid Condition	☐	☐
Other:		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			
	☐ Other			

What types of exercise do you perform? _____

What things cause stress in your life?

Are you taking any seizure medication? ☐ Yes ☐ No If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐ Yes ☐ No If yes list name: _____

List all medications you are currently taking: _____

List all surgeries (including dates): _____

Are you pregnant? ☐ Yes ☐ No What week? _____

Have you had any injuries related to work? ☐ Yes ☐ No If yes list body part and date.: _____

Have you had any auto accidents? ☐ Yes ☐ No If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ Yes ☐ No Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

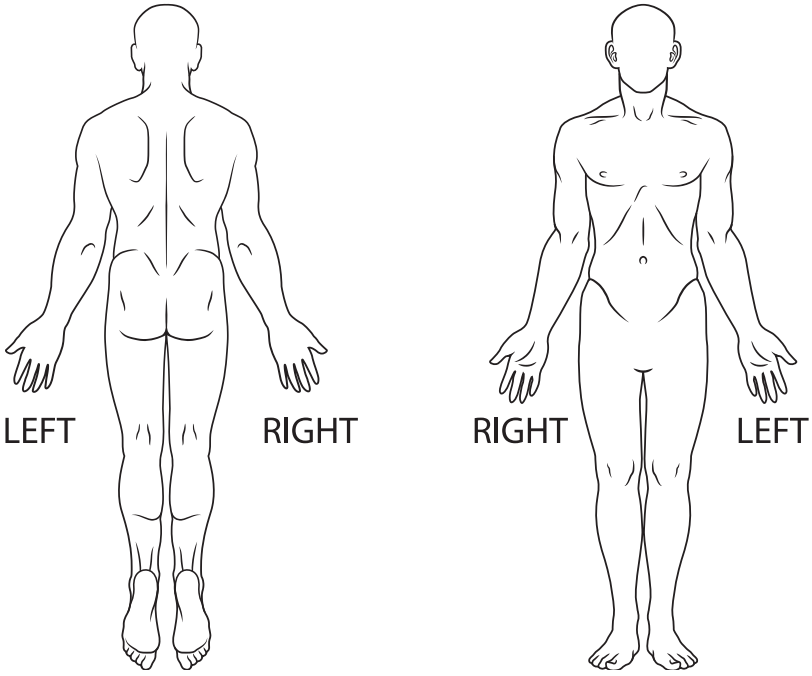
Pain and Symptom Status Report

Name _____ Date _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

Ache	Burning	Numbness
MMM	— — —	0 0 0 0
M	— —	0 0 0

Pins and Needles	Stabbing	Other
□ □ □ □ □ □	/////	x x x x
□ □ □ □	////	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of Your Problem Occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>LOWEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>HIGEST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**

Additional Comments: _____

_____

What goals do you wish to achieve in physical therapy? _____

_____

_____

_____

_____

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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as MovementPlus Physical Therapy or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

_____

Name of Patient (Print Clearly)

_____

Signature of Patient Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient