SYMMETRY
PHYSICAL THERAPY

270 Main Street
Portland, CT 06480-1859
860-788-7976 phone
877-532-7987 fax
www.symmetryusa.net

Patient Name: _____ DOB: _____ Date : _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

E-mail: _____Do you want e-mail appointment reminders? ☐ Y ☐ N

Employer: _____Work Phone: _____

Emergency Contact_____ Phone: _____ Relation? _____

Attorney Name: _____ Phone Number: _____

Have you had any prior Therapy this past year? ☐ Y ☐ N How many visits? _____

How did you hear about us? ☐ Friend/Family ☐ Newspaper ☐ Internet ☐ Doctor ☐ Insurance ☐ Prior Patient

☐ Other, please describe: _____

.....Please answer highlighted only.....

Referring Physician: _____ **NPI #:** _____

Primary Insurance Co: _____ WC HMO PPO MC Other_____

Address: _____

City_____ State_____Zip_____

Phone: _____ Billing F a x : _____

Policy/claim#: _____Group#: _____

Effective date of insurance: _____Pre-Cert Required? #: _____

Insured's Name: _____Insured's DOB: _____

Insured's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other

In Network: Deductible: $_____ Co-Pay: $_____Co-Insurance (% covered): _____%

Out of Network: Deductible: $_____ Co-Pay: $_____ Co-Insurance (% covered): _____%

Visit Limit per Dx: _____ Per Year: _____ F i s c a l Limit per Dx: $_____ P e r Year: $_____

Out of pocket Max: _____. Deductible Met: ☐ Y ☐ N Remaining amount: _____

Secondary Ins: _____

Policy/claim#: _____Group#: _____

Effective date of insurance: _____Pre-Cert Required? #: _____

Insured's Name: _____Insured's DOB: _____

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PATIENT MEDICAL HISTORY

Name: _____ Date of Injury:_____

Family Physician:_____Phone: _____

Referring Physician:_____Body Part:_____

Medications:_____

Allergies: _____

Did you have surgery? No Date of Surgery: Procedure:_____

Have you had any of the following for your condition? ☐ PT ☐ X-ray ☐ MRI ☐ Chiropractic ☐ Injections

MEDICAL HISTORY QUESTIONNAIRE

☐ Arthritis
☐ High Blood Pressure
☐ High Cholesterol
☐ Diabetes
☐ Osteoporosis
☐ Cancer: Type:_____
Year:_____
☐ Stroke
☐ Depression
☐ Smoker
☐ Liver Disease
☐ Fibromyalgia
☐ Chronic Fatigue Syndrome
☐ Multiple Sclerosis
☐ Thyroid dysfunction Hypo Hyper
☐ HIV/AIDS

☐ Recent weight GAIN / LOSS
☐ Numbness/tingling
☐ Night Sweats
☐ Rheumatoid Arthritis
☐ Kidney Dysfunction
☐ Dialysis
☐ Blood Disorder
☐ Total Joint Replacement

☐ Type:_____
Headaches
☐ Heart Disease
☐ Pacemaker
☐ Shortness of Breath
☐ Angina

☐ Spinal cord injury

☐ Chest pain
☐ Dizziness/Lightheadedness
☐ Lyme Disease
☐ Asthma
☐ Emphysema
☐ COPD
☐ Tuberculosis
☐ Seizures/Epilepsy
☐ Back injury
☐ Neck Injury
☐ Hernia
☐ Pregnant?_____ mos.
☐ Liver Dysfunction

☐ Hepatitis A B C (circle)
☐ Traumatic brain injury

Other, not listed above:

Please check your current pain level, 0 = no pain, 10 = emergency room pain:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain when it is at it's worst:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Patient Authorization Record

Initial here

	Authorization for Treatment ➢ I hereby authorize Symmetry Physical Therapy to provide physical therapy treatment and/or procedures that have been described to me. The inherent risks and benefits of such procedures have been explained, as well as alternate treatment options. I understand that my decision to allow Symmetry Physical Therapy to provide such treatment and/or procedures is completely voluntary and I have the right to refuse any such treatment and/or procedures at any time.
	Authorization for Release of Information ➢ I agree that Symmetry Physical Therapy may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Symmetry Physical Therapy for services rendered. ➢ I agree that Symmetry Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read or been offered the "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to Symmetry Physical Therapy for services rendered.
	Patient Agreement ➢ I agree to pay Symmetry Physical Therapy charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Symmetry Physical Therapy collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ➢ I agree that the information given to Symmetry Physical Therapy in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Symmetry Physical Therapy may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation ➢ I agree that the information given to Symmetry Physical Therapy in applying for benefits under Workers Compensation is complete and accurate. I agree that Symmetry Physical Therapy may give intermediary's information necessary to process claims.

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Cancellation and No Show Policy

Failure to keep your scheduled appointments hinders our ability to provide the best possible care to all of our patients. *Symmetry Physical Therapy* asks that you show us consideration by calling at least 24 hours prior to your appointment if you are unable to attend. This will allow us the opportunity to offer that appointment to another patient. ALL missed appointments MUST be made up the same week so you may fully recover from your condition.

Our Cancellation Policy is:

∞ **Failure to give 24 hours notice prior to cancellation will result in a "No-Show Appointment Fee" of $25.**

This fee cannot be billed to your insurance company and will be your direct responsibility.

∞ Repeated late cancellations or no-shows are disruptive to the optimal delivery of care to you and our other patients, therefore:

3 late cancellations or no shows will result in discontinuing physical therapy.

I, _____ have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

Patient/legal guardian INITIAL HERE: _____

RELEASE OF INFORMATION

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.
I authorize Symmetry Physical Therapy to disclose my health information that is directly related to my current treatment at Symmetry Physical Therapy to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

NAME	RELATIONSHIP

I attest that all of the above information has been documented accurately and to the best of my knowledge, and I agree to adhere to all policies and procedures outlined above,

Patient/Legal Guardian/LPOA signature:_____ Date:_____

Oswestry Low Back Pain Disability Questionnaire

Name: **Date:** Office Use Score:

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just check the box that indicates the statement which most clearly describes your problem.

Section 1- Pain intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, grooming, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 - Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg on a table
- ☐ Pain prevents me from lifting heavy weight, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

Section 4 - Walking

- ☐ Pain does not prevent me from walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than a ½ mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5 – Sitting

☐ I can sit in any chair as long as I like

☐ I can only sit in my favorite chair as long as I like

☐ Pain prevents me from sitting more than one hour

☐ Pain prevents me from sitting more than ½ an hour

☐ Pain prevents me from sitting more than 10 minutes

☐ Pain prevents me from sitting at all

Section 6 – Standing

☐ I can stand as long as I want without extra pain

☐ I can stand as long as I want but it gives me extra pain

☐ Pain prevents me from standing more than one hour

☐ Pain prevents me from standing more than 30 minutes

☐ Pain prevents me from standing for more than 10 minutes

☐ Pain prevents me from standing at all

Section 7 – Sleeping

☐ My sleep is never disturbed by pain

☐ My sleep is occasionally disturbed by pain

☐ Because of my pain I have less than 6 hours sleep

☐ Because of my pain I have less than 4 hours sleep

☐ Because of my pain I have less than 2 hours sleep

☐ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable, you may skip section)

☐ My sex life is normal and causes no extra pain

☐ My sex life is normal but causes some extra pain

☐ My sex life is nearly normal but is very painful

☐ My sex life is severely restricted by pain

☐ My sex life is nearly absent because of pain

☐ Pain prevents any sex life at all

Section 9 – Social life

☐ My social life is normal and gives me no extra pain

☐ My social life is normal but increases the degree of pain

☐ Pain has no significant effect on my social life apart from limiting more energetic interests eg sports

☐ Pain has restricted my social life and I do not go out as often

☐ Pain has restricted my social life to my home

☐ I have no social life because of pain

Section 10 – Travel

☐ I can travel anywhere without pain

☐ I can travel anywhere but it gives me extra pain

☐ Pain is bad but I manage journeys over two hours

☐ Pain restricts me to journeys of less than one hour

☐ Pain restricts me to short necessary journeys under 30 minutes

☐ Pain prevents me from traveling except to receive treatment