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 Fax : ______________________

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: ________ Fiscal Limit per Dx: $________ Per 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? 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

**Patient Authorization Record**

| Initial here | |
|---|---|
| | **Authorization for Treatment**<br>➢ 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**<br>➢ I agree that Symmetry Physical Therapy may provide information from my medical record to persons involved in my medical care.<br>➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Symmetry Physical Therapy for services rendered.<br>➢ 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.<br>➢ I have read or been offered the "Notice of Privacy Practices" mandated by HIPAA. |
| | **Authorization for Release of Payment**<br>➢ I authorize that direct payment of any benefits available to me be released to Symmetry Physical Therapy for services rendered. |
| | **Patient Agreement**<br>➢ I agree to pay Symmetry Physical Therapy charges for services rendered to me during my course of treatment.<br>➢ 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**<br>➢ 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**<br>➢ 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. |

## 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:____________

## NECK PAIN DISABILITY INDEX QUESTIONNAIRE

*PLEASE READ*: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

### *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, 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 positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights, 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 6 - Concentration*

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

### *SECTION 7 - Work*

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

### *SECTION 8 - Driving*

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

***SECTION 4 - Reading***

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I cannot read as much as I want because of severe pain in my neck.
- ☐ I cannot read at all.

***SECTION 9 - Sleeping***

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours).

***SECTION 5 - Headaches***

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

***SECTION 10 – Recreation***

- ☐ I am able to engage in all of my recreational activities with no neck pain at all.
- ☐ I am able to engage in all of my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I cannot do any recreational activities at all.

**For office use only, SCORE:**