Patient Functional Assessment Questionnaire

Patient Name:_____ **Date:**_____

INSTRUCTIONS: Circle the level of difficulty for each activity		0 = Absolutely no difficulty	1 = Able to do w/ little difficulty	2 = Able to do w/ little to moderate difficulty	3 = Able to do w/ moderate difficulty	4 = Able to do w/ moderate to significant difficulty	5 = Able to do w/ significant difficulty	6 = Unable to do at all	Not Applicable
Mobility/Walking	Walking short distances	0	1	2	3	4	5	6	n/a
	Walking long distances	0	1	2	3	4	5	6	n/a
	Walking outdoors	0	1	2	3	4	5	6	n/a
	Climbing Stairs	0	1	2	3	4	5	6	n/a
	Hopping	0	1	2	3	4	5	6	n/a
	Running	0	1	2	3	4	5	6	n/a
Change/Maintain Body Position	Rolling over	0	1	2	3	4	5	6	n/a
	Moving – lying to sitting	0	1	2	3	4	5	6	n/a
	Sitting	0	1	2	3	4	5	6	n/a
	Bending/ Stooping	0	1	2	3	4	5	6	n/a
	Kneeling	0	1	2	3	4	5	6	n/a
	Standing	0	1	2	3	4	5	6	n/a
Carry / Move / Handle Objects	Pushing	0	1	2	3	4	5	6	n/a
	Pulling	0	1	2	3	4	5	6	n/a
	Reaching	0	1	2	3	4	5	6	n/a
	Grasping	0	1	2	3	4	5	6	n/a
	Lifting	0	1	2	3	4	5	6	n/a
	Carrying	0	1	2	3	4	5	6	n/a
Self Care	Dressing/ Clasp b/h back	0	1	2	3	4	5	6	n/a
	Doing light housework	0	1	2	3	4	5	6	n/a
	Prep meals/kitchen tasks	0	1	2	3	4	5	6	n/a
	Bathroom activities	0	1	2	3	4	5	6	n/a
	Sleeping Ability	0	1	2	3	4	5	6	n/a
	Hygiene (comb hair/brush teeth)	0	1	2	3	4	5	6	n/a

Patient Signature: _____ **Date:**_____
Reviewed by Therapist/Credentials: _____ **Date:** _____

The Physical Therapy Connection
Patient information

Date:_____

Patient's Name:_____
Date of Birth:_____ Age:_____
Address:_____
Phone:_____ Email:_____
Any restriction to contact you? Yes No
Is your condition related to: (please circle) work auto neither
Referring doctor:_____

Patient's Employer:_____
Occupation:_____
Employment:(please circle) full-time part-time retired unemployed
Contact person (if work related):_____
Contact phone:_____
Work status: (please circle) no restrictions restrictions off work
Goal date to return to work, if applicable:_____

Primary Health Insurance:_____
Insured's name:_____Date of birth:_____
Policy number:_____
Group number:_____
Do you have a co-pay?_____
*Secondary Health Insurance:_____
Insured's name:_____Date of birth:_____
Policy number:_____Group number:_____

Emergency Contact:_____
Phone number:_____
Relationship to patient:_____

Date of follow-up appointment with your doctor?_____

How did you hear about us?

___Doctor recommended
___Family or friend
___Walk-in
___Conquest Fitness
___Internet/Facebook
___Web site
___TV
___Other-Please specify:
_____

Health Information

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Height:_____ Weight:_____

Date of injury:_____ Date of Surgery:_____

How did your problem occur?_____

Location of pain:_____

Chief complaint:_____

Diagnostic Tests:(please circle) X-rays MRI CT Scan EMG Other_____

Results:_____

Related treatments:(example: injections, chiropractor)_____

_____

List previous injury or surgery that may affect treatment:_____

_____

List any serious illnesses that may affect treatment:_____

_____

Do you have any of the following? (please check)

___AIDS/HIV
___Asthma
___Bronchitis
___Depression
___Diabetes
___Dizziness/Vertigo
___Epilepsy/Seizures
___Facial Pain
___Headaches/Migraine
___Hepatitis
___High/Low Blood Pressure
___Hypothyroidism
___Hyperthyroidism
___Irritable bowel/Crohn's
___Metal Implants
___Osteoporosis
___Pneumonia
___Pregnancy(currently)
___Sinus Infections
___Sleep apnea
___Stroke
___Tuberculosis
___Ulcers
___High Cholesterol

Additional Comments:

_____

_____

_____

_____

Do you have heart issues/surgery? Please specify_____

Kidney Issues? Please specify_____

Cancer? Please specify?_____

Have you fallen in the past year?_____ If so, how many times?_____

When was your last fall?_____

Pain rating:
-Please circle your pain level with activity.
-Please place an X over your pain level at rest.

0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

Do you have difficulty sleeping? yes no

Pain is increased by:_____
Pain is decreased by:_____

Please list any medications that you are presently taking:_____
_____
_____

Please list any allergies or sensitivities (Example: meds, latex, adhesives):_____
_____

Have you received previous physical therapy services this year? yes no

If so, how many visits and when? _____

Are you currently receiving any type of home health services? yes no

If so, what type of services? _____

Appointment Cancellation/No-Show Policy Agreement

The Physical Therapy Connection is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (517)668-0000 by 3:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 3:00 p.m. on *Friday*.** If prior notification is not given, you will be charged $75.00 for the missed appointment. This charge will not be billed to your insurance company; it will be billed to you directly. Thank you for your understanding regarding this matter.
INITIAL: _____

Billing/Payment Policy

We highly recommend you contact your insurance carrier and check into your coverage for physical therapy. Do not assume that you will not owe anything if you have more than one insurance policy.

It is the policy of The Physical Therapy Connection, Inc. that payment is due at the time of service unless financial arrangements are made in advance. We require all patients to pay deductible, copay and/or coinsurance payment at the beginning of each visit. After your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Accepting your insurance does not place any financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral is not a guarantee of payment.

Worker's Comp/Auto: Please let us know at your first appointment if this injury is a Worker's Compensation or Auto claim. We will need a claim number, point of contact name and phone number at your first visit. If we are not notified at your first visit we will bill your health insurance company and it is your responsibility to get it covered and paid for by worker's comp or auto insurance.

Payment Methods: We accept cash, check, CareCredit, Visa, MasterCard, Discover, and American Express.

Payment Policy/Collection Fees: We will bill you twice and if no payment is received we will add a finance charge of 20% to your bill each month you are late. After three billing cycle's we will refer your account to collections or small claims court. In the event your account is placed in collection status or sent to small claims court, any additional fees incurred due to this, will be added to your outstanding balance.

Credit Card on File: We do require a credit card on file for any patients with deductibles and copays. Your card will be charged the full amount owed if we have billed you twice with no payments made.

Divorced Parents of Patients: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I am authorizing The Physical Therapy Connection, Inc. to bill my insurance company for all services. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

_____

Please Print the Name of Patient

I authorize The Physical Therapy Connection to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ **Amex** ☐ **Visa** ☐ **Mastercard** ☐ **Discover**

Credit Card Number _____
Expiration Date _____ **/** _____ **/** _____
Csv_____
Cardholder Name _____
Billing Address _____
City _____ **State**_____ **Zip** _____

I (we), the undersigned, authorize and request The Physical Therapy Connection to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by The Physical Therapy Connection.
This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to The Physical Therapy Connection in writing and the account must be in good standing.

Patient Name (Print): _____
Patient Signature: _____
Date: _____ / _____ / _____

Consent for Treatment

I hereby give consent to The Physical Therapy Connection, Inc. and its designated agents to provide evaluative and treatment services as necessary and reasonable for my care.

_____ _____
Signature Date