Physical Therapy Medical Screening Questionnaire

Name: _____ **Date:** _____ **Age:** _____

Are you latex sensitive? ❑Yes ❑No

Do you smoke? ❑Yes ❑No

Do you have a pacemaker? ❑Yes ❑No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ❑Yes ❑No

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down, depressed or hopeless? ❑**YES** ❑**NO**
During the past month have you been bothered by having little interest or pleasure in doing things? ❑**YES** ❑**NO**
If yes to either, is this something with which you would like help? ❑**YES** ❑**YES, but NOT today** ❑**NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

_____

_____

Have you ever taken steroid medications for any medical conditions? ❑**YES** ❑**NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ❑**YES** ❑**NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

_____

_____

What date (roughly) did your present problem start?_____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

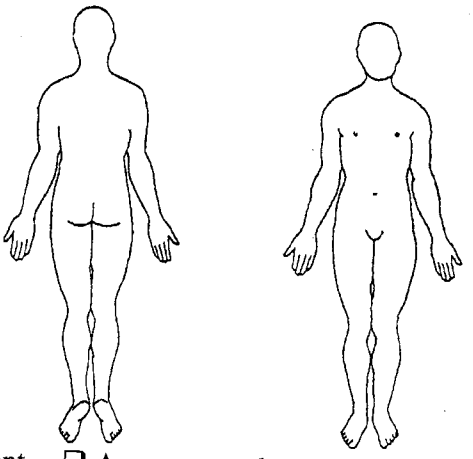
Treatment received so far for this problem (chiropractic, injections, surgery, etc): _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Circle your **current** level of pain while completing this survey: ...0...1...2...3...4...5...6...7...8...9...10...

Circle the **best** your pain has been during the past 24 hours: ...0...1...2...3...4...5...6...7...8...9...10...

Circle the **worst** your pain has been during the past 24 hours: ...0...1...2...3...4...5...6...7...8...9...10...

Easing Factors: Identify **up to 3** important positions or activities that make your symptoms *better*:
1. _____
2. _____
3. _____

Aggravating Factors: Identify **up to 3** important activities that you are unable to do or are having difficulty with as a result of your problem.
1. _____
2. _____
3. _____

[redacted]

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After activity
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After activity

Patient Signature:_____

LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

LOUDOUN MEDICAL GROUP

DEMOGRAPHICS

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	SEX	PREFIX/SUFFIX
DATE OF BIRTH *(mm/dd/yy)*	STATUS *(please circle one)* Single Married Divorced Widowed Partner	STUDENT *(please circle one)* No Full Time Part Time
STREET ADDRESS	CITY/STATE	ZIP CODE
HOME PHONE *(include area code)*	WORK PHONE	CELL PHONE
RACE *(please circle one)* White Black/African American Asian Hawaiian/Other Pacific Islander Other Race American Indian/Alaska Native	ETHNICITY *(please circle one)* Hispanic or Latino Not Hispanic or Latino Unknown	PREFERRED LANGUAGE English Spanish Or other: _____
EMPLOYER / JOB TITLE/STATUS	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER
PREFERRED PHARMACY / PHARMACY PHONE NUMBER	EMAIL ADDRESS	

CONTACT/GUARANTOR INFORMATION

CONTACT *(please circle at least one)* Emergency Contact Next of Kin Insured Authorized to Seek Treatment	LAST NAME	FIRST NAME	MIDDLE INITIAL
SSN *(social security number)* / DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX / MARITAL STATUS	
HOME ADDRESS	CITY/STATE	ZIP CODE / HOME PHONE	
EMPLOYER	WORK PHONE	JOB TITLE	

If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party.

CONTACT *(please circle at least one)* **Guarantor** Emergency Contact Next of Kin Insured Authorized to Seek Treatment	LAST NAME	FIRST NAME	MIDDLE INITIAL
SSN *(social security number)* / DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS
HOME ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE
EMPLOYER	WORK PHONE	JOB TITLE	

Over

INSURANCE POLICY INFORMATION

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? Yes No	END DATE	COPAYMENT AMOUNT Office: $_____ Specialist: $_____
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE
INSURED'S MAILING ADDRESS	PRIMARY CARE PHYSCIAN (pcp)		

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? Yes No	END DATE	COPAYMENT AMOUNT Office: $_____ Specialist: $_____
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or another health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third-party servicer acting for LMG, PC or any of its affiliates.

_____

Print Name

_____

Signature

_____

Date

Patient Authorization

I authorize my insurance benefits to be paid directly to the healthcare provider and I am financially responsible for all charges. I hereby consent to the release and disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third-party payer, health maintenance organization, insurer or another health benefit plan. This consent applies to Loudoun Medical Group LMG, PC, or any of its affiliates or agents, lenders or any third-party servicer acting for LMG, PC, or any of its affiliates.

I agree to promptly pay for services rendered for me or the patient named below. If I fail to meet my financial commitment to LMG and it becomes necessary to take any action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time stated in the No Show/Cancellation policy.

I hereby understand that with treatment by any LMG office I have given consent to testing and release of the test results related to infection with human immunodeficiency virus or hepatitis B or C viruses, if in their opinion, an employee has suffered an exposure incident because of my treatment, as defined by the Center for Disease Control and Occupational Safety and Health Administration. I understand I have consented to the release of such test results to the person that was exposed.

_____ _____

Patient/Guardian Signature Date

General Acknowledgement and Payment

Payment is due at the time of service. Payment arrangements may be available by request and will be enforced. You may receive a statement for services, which you agree to pay, if you do not present at the time of your visit a prescription and authorization/referral, if necessary, from the physician involved in your care, and a current copy of your insurance card(s). If you are a self-pay patient, payment arrangements must be made prior to your first appointment by calling Holly Lehrer at 703-737-6001 ext. 6139. You may also receive a statement for services, which you agree to pay, should you fail to disclose that you have a deductible or co-insurance obligation, or that your insurance carrier determines our treatment of your condition is not medically necessary, or is not covered for other reasons.

Have you ever received physical therapy at any outpatient facility other than Optimum Physical & Sports Medicine **THIS YEAR**?

(Circle one) YES NO

_____ _____

Patient/Guardian Signature Date

NOTICE TO AND AGREEMENT BY MEDICARE PATIENTS ONLY – CONTINUE & SIGN BELOW

Medicare and your private insurance carrier will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare Law. During your treatment, we may provide you with useful and beneficial services that Medicare decides are not "reasonable and necessary." Nevertheless, you will be responsible for paying charges associated with those services, and by signing this form, you agree to do so. Accordingly, it will be your responsibility to ascertain whether Medicare and your insurance cover any services we provide you *** **There is a $2010 per calendar year CAP for out-patient Physical and Occupational therapy for 2018*****

_____ _____

Patient/ Guardian Signature Date

224-D Cornwall St. NW #200 Leesburg, VA. P(703)443-2223 F(703)4432690
205 E. Hirst Rd. #201 Purcellville, Va. P(540)751-4455 F(540)338-3230
www.OptimumPT-LMG.com

It is important to keep your scheduled appointments.

The Cancellation Policy/No Show Fee for appointments is as follows:

A fee of $50 will be charged for any missed appointments or appointments cancelled without 24 hour notice.

Appointments cancelled within a 24 hour time frame will not be charged this fee.

_____ _____

Patient/Guardian Signature Date

LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

_____
Patient's Name

I have a received a copy of Loudoun Medical Group's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

_____
Signature

Date: _____

_____
Relationship to Patient (if Acknowledgement Form is executed by someone other than the Patient)

FOR OFFICE USE ONLY

I attempted to obtain the patient's/representative's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Staff Initials	Reason
		Refused to sign (circle if applicable) **Other:**