INNOVA
PHYSICAL THERAPY TRANSFORMED

Patient Information (Please Print)

First Name _____ MI _____ Last Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home ( ) _____ Cell ( ) _____ Work ( ) _____

Email _____ Gender ☐ Male ☐ Female

Who may we thank for referring you? Provider Family/Friend Other _____

Emergency Contact

Name _____ Phone ( ) _____ Relationship _____

Problem

Referring Provider _____ Primary Care Physician _____

Injury/ Body Part Involved _____ ☐ Right ☐ Left

Last MD Visit _____ Have you previously been treated by a Physical Therapist this year? ☐ Yes ☐ No

Insurance Information

Primary Insurance _____ Secondary Insurance _____

Subscriber Name _____ Subscriber Name _____

Subscriber DOB _____ Subscriber DOB _____

Relationship to Subscriber _____ Relationship to Subscriber _____

ID # _____ Group # _____ ID # _____ Group # _____

Work Related Injury or Motor Vehicle Accident

☐ Work Related ☐ MVA Claim No. _____ Date of Injury _____

Insurance Name _____ Insurance Billing Address _____

Claim Manager's Name _____ Phone ( ) _____

Agreement

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services. I also authorize Innova Physical Therapy to release any information to referring/consulting physicians or other health care providers as deemed appropriate to facilitate my/our care.

Signature (Parent/ Guardian if patient is a minor) _____ Date _____

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Name _____

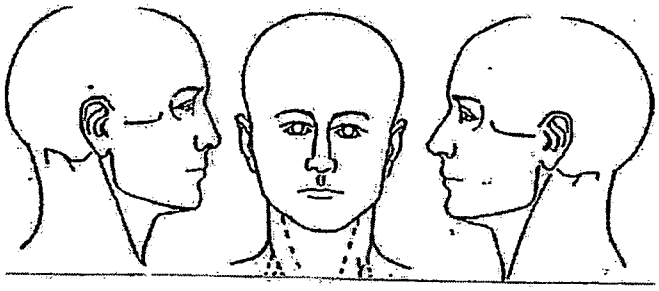
Date _____

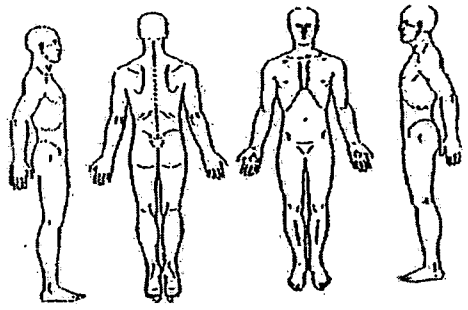
TMD Intake Form

1. What problem are you here for today?

2. Describe how and when your problem occurred:

3a. Please mark, on the body chart below, your areas of discomfort:





3b. Check the intensity of your discomfort:
0= no pain 10 = pain so intense you need to go to E.R.

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

3c. Check the box that best describes how your discomfort changes during the day:

	Morning	Afternoon	Evening
Better	☐	☐	☐
Worse	☐	☐	☐

4. Does your pain wake you at night? YES ☐ NO ☐ If YES, how many times per night?

5. Which activities increase your symptoms?

☐ Talking ☐ Laughing ☐ Eating ☐ Lying on Left Face
☐ Stress ☐ Swallowing ☐ Yawning ☐ Lying on Right Face
Other: ☐ Brushing Teeth

6. What eases your symptoms?

☐ Heat ☐ Ice ☐ Rest ☐ Medication
☐ Change in Position Other

7. Have you had a similar problem before? YES ☐ NO ☐
If YES, when?

8. Have you had treatment for this problem before? YES ☐ NO ☐ If YES, when?

9. Prior to your recent illness/injury, were you able to perform your daily activities without limitation?

☐ No, I was severely limited (0-25%) ☐ I was moderately limited (25-50%) ☐ I was minimally limited (50-75%) ☐ I could do most things (75-90%) ☐ Everything! (90-100%)

Please Explain:

10. Since to your recent illness/injury, are you able to perform your daily activities without limitation?

☐ No, I was severely limited (0-25%) ☐ I was moderately limited (25-50%) ☐ I was minimally limited (50-75%) ☐ I could do most things (75-90%) ☐ Everything! (90-100%)

Please Explain:

11. Are you currently taking any medication for this, or any other medical problem? YES ☐ NO ☐

If YES, please give name:

12. Have you had any long-term use of Prednisone, Cortisone, steroids, inhalants? YES ☐ NO ☐

If YES, please specify

13. Have you had any tests for your current problem? YES ☐ NO ☐ If YES, please check all that apply:

☐ X-rays ☐ Bone Scan ☐ Coned Beam Scan ☐ MRI ☐ Nerve Tests

Results, if known:

14. Please circle if you have experienced any of the following with your current problem:

☐ locking ☐ giving way ☐ loss of balance ☐ pain with cough/sneeze
☐ buckling ☐ dislocating ☐ unconsciousness ☐ dizziness or blurred vision
☐ lip numbness

15. How would you rate your overall health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

16: Your age: Height Weight lbs. Do you exercise regularly? YES ☐ NO ☐

Do you smoke? YES ☐ NO ☐

17. Are you pregnant at this time? YES ☐ NO ☐ Not applicable ☐

18. Please check if you have had any of the following, at any time in your life.

☐ cancer ☐ lung problems ☐ allergies ☐ heart disorder ☐ stroke ☐ hepatitis
☐ arthritis ☐ sprains/strains ☐ whiplash ☐ osteoporosis ☐ surgeries ☐ nerve disorder
☐ asthma ☐ tuberculosis ☐ concussion ☐ broken bones ☐ blood clots ☐ high blood pressure
☐ seizures ☐ unusual/frequent headaches ☐ **other**

Please describe any circled or "other" items:

22. What are your goals and expectations for Physical/Occupational Therapy?

Please print this form, sign, and bring with you to your first appointment

Patient Signature: _____

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and **mark in each section only the one box that applies to you.** We realise you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem

Office Use Only

Name _____

Date _____

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 can 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 lifting heavy weights off the floor, but I can manage if they are conveniently placed, 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 only lift very light weights
☐ I cannot lift or carry anything

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 with moderate pain in my neck
☐ I can't read as much as I want because of moderate pain in my neck
☐ I can hardly read at all because of severe pain in my neck
☐ I cannot read at all

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 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 can't 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 can't 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 can't drive my car at all

Section 9: Sleeping

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

Section 10: Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all
☐ I am able to engage in all my recreation activities, with some pain in my neck
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck
☐ I can hardly do any recreation activities because of pain in my neck
☐ I can't do any recreation activities at all

Score: ___/50 **Transform to percentage score x 100 = %points**

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example:16 (total scored)
50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

16 (total scored)
45 (total possible score) x 100 = 35.5%

Minimum Detectable Change (90% confidence): 5 points or 10 %points

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NDI developed by: Vernon, H. & Mior, S. (1991). The Neck Disability Index: A study of reliability and validity. Journal of Manipulative and Physiological Therapeutics. 14, 409-415

Appendix IV (i)

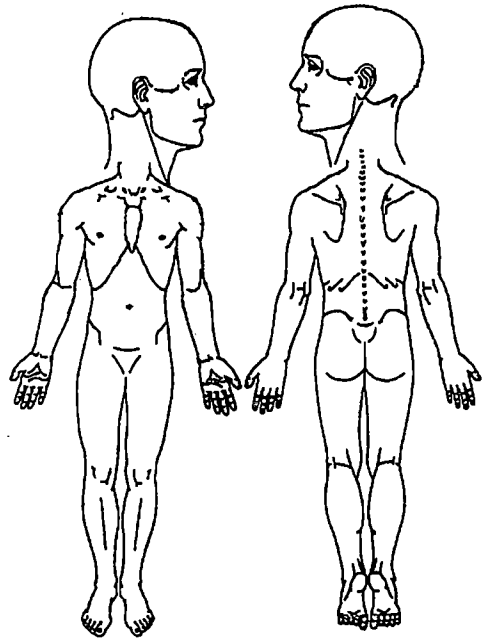
SHORT FORM McGILL PAIN QUESTIONNAIRE and PAIN DIAGRAM

Date: _____

Name: _____

Check the column to indicate the level of your pain for each word, or leave blank if it does not apply to you.__

		Mild	Moderate	Severe
1	Throbbing			
2	Shooting			
3	Stabbing			
4	Sharp			
5	Cramping			
6	Gnawing			
7	Hot-burning			
8	Aching			
9	Heavy			
10	Tender			
11	Splitting			
12	Tiring-Exhausting			
13	Sickening			
14	Fearful			
15	Cruel-Punishing			



Mark or comment on the above figure where you have your pain or problems.

Indicate on this line how bad your pain is—at the left end of line means no pain at all, at right end means worst pain possible.

No Pain _____ Worst Possible Pain

S /33 A /12 VAS /10

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FINANCIAL POLICY

Standard Insurance Policy:
Innova will bill your insurance carrier as a courtesy to you. However, you are ultimately responsible for payment for services you receive. If we are contracted with your insurance company, we must follow our contract and their requirements. It is the insurance company that makes the final determination of your eligibility.

If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain the referral may result in a lower payment from the insurance company. Referrals are current for 90 days unless otherwise specified.

Copays are due at the time of service. It is your responsibility to know the amount of your copay. My copay is $.

The balance on your monthly statement is due and payable when the statement is issued, and is past due if not paid by the due date on the statement. Payment plans are available upon request.

Self-Pay Policy:
Innova will apply a discount for patients without insurance coverage, or for those patients that have exceeded insurance benefits. Payment is due at the time services are rendered.

Auto PIP/ Third Party Policy:
We do not accept third-party or accident settlement *liens*. If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. We require that you allow us to bill your health insurance or pay our self-pay rates at the time of service.

Cancellation Policy:
The appointments made for you represent a time set aside specifically for you and your therapist. We value your time and ask that you value ours by giving at least 24 hours' notice for any cancellations or changes to your appointment.

Patients who fail to provide **24 hours' notice** will be charged a **$60.00 fee.** This fee is not billable to insurance and is due at your next scheduled appointment. Patients who cancel or no show on three separate occasions will be discharged from physical therapy and removed from the schedule. In the event that you are discharged from our care, your referring provider or case manager will be notified of the reason for discharge.

If you have any questions regarding this policy, please do not hesitate to contact our *Clinic Director* at: (425) 658-4980

I understand the Financial Policies as described above. I acknowledge that I am financially responsible for any balance due on covered or non-covered services.

Signature (Parent/ Guardian if patient is a minor) _____ Date _____

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PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Information Portability and Accountability Act (HIPAA). I have been given the right to review and receive a copy of Innova's Notice of Privacy Practices. I understand that Innova Physical Therapy will use or disclose my health information for treatment, billing and healthcare operation. I understand that I have the right to request in writing how my private information is used or disclosed.

Signature (Parent/ Guardian if patient is a minor) _____ Date _____