PT@CSULB BEACH
PHYSICAL THERAPY FACULTY PRACTICE

Physical Therapy Faculty Practice
California State University, Long Beach
1250 Bellflower Blvd, KIN-105
Long Beach, CA 90840

Phone: (562) 985-8286
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Email: CHHS-PTBeach@csulb.edu
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Name: _____ **Date:** _____

Height: _____ Weight: _____ Gender: _____ DOB: _____

Address: _____
City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____
Work phone: _____ Email address: _____

How did you hear about us?
❑ Facebook ❑ LifeFit ❑ Former Patient ❑ Yelp ❑ Other: _____

Emergency Contact Information:
Name: _____ Phone: _____

Physician Contact Information (Primary/Referring):
Name: _____ Phone: _____
Specialty: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip: _____

Please list any medications you are currently taking (including frequency and dosage):
_____
_____
_____
_____

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

Please list any allergies you have (including sensitivity to latex):
_____
_____

Please answer "yes" or "no" to the following questions:

Yes	**No**	
❑	❑	Are you on a work restriction from your doctor?
❑	❑	Do you have a pacemaker?
❑	❑	Do you smoke?
❑	❑	Have you ever taken steroid medications for any medical conditions?
❑	❑	Have you ever taken blood thinning or anticoagulant medications for any medical conditions?
❑	❑	Have you had any injections for your current problem?
❑	❑	Do you have any surgical implants (i.e. plastic, metal, etc.)?
		If so, please elaborate: _____
❑	❑	Are you currently pregnant or do you think you might be pregnant?
❑	❑	During the past month have you been feeling down, depressed, or hopeless?
❑	❑	During the past month have you been bothered by having little interest or pleasure in doing things?
❑	❑	Is this something with which you would like help?
❑	❑	Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?

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

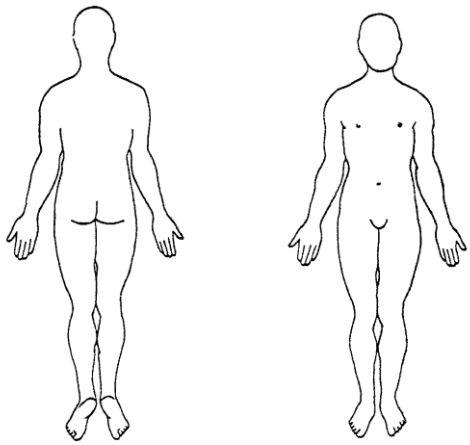
Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ 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

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 the intensity changes with activity

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

What do you think caused your symptoms? _____

What activities/positions/movements make your symptoms worse? _____
_____

What activities/positions/movements make your symptoms better? _____
_____

My symptoms are currently: ❑ Getting better ❑ Getting worse ❑ Staying about the same

Have you ever had this problem before? ❑ Yes ❑ No
If so, when? _____ How long did it take for you to feel better? _____
Treatment (physical therapy, chiropractic, injections, etc.): _____
_____

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

Have you received physical therapy in this calendar year? ❑ Yes ❑ No

Leisure activities, including exercise routines: _____
_____

Occupation, including activities that comprise your workday: _____
_____

How do your symptoms affect your sleep?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

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

On a scale of 0 to 10, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:
Your current level of pain while completing this survey: _____
The best your pain has been during the past 24 hours: _____
The worst your pain has been during the past 24 hours: _____

What is your personal goal for physical therapy? _____

I understand that the above information is a full and accurate report of my medical history. This information will be utilized by my physical therapist to develop the best possible treatment and exercise program for me.

_____	_____	_____	_____
Patient's Signature	Date	Physical Therapist's Signature	Date

Insurance Information

Workers' Compensation Patients Only:

Social Security Number: _____

Employer Contact Information:

Name: _____ Phone: _____

Address: _____

_____

Title/Position: _____ Status: ❑ Employed ❑ Unemployed ❑ Other: _____

PPO Plan Patients Only:

Primary Insurance:

Company Name: _____ Phone: _____

Insurance ID Number: _____ Group Number: _____

If policyholder is someone other than yourself:

Policyholder's First Name: _____ Last Name: _____

Policyholder's Date of Birth: _____ /_____ /_____ Policyholder's Sex: ❑ Male ❑ Female

Policyholder's Social Security Number: _____ - _____ - _____ Relationship: _____

Policyholder's Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance: ❑ HMO ❑ PPO

Company Name: _____ Phone: _____

Insurance ID Number: _____ Group Number: _____

If policyholder is someone other than yourself:

Policyholder's First Name: _____ Last Name: _____

Policyholder's Date of Birth: _____ /_____ /_____ Policyholder's Sex: ❑ Male ❑ Female

Policyholder's Social Security Number: _____ - _____ - _____ Relationship: _____

Policyholder's Address: _____

City: _____ State: _____ Zip: _____

Please read through the following sections carefully. By initialing on each line below, you are acknowledging you have read, understood, and accepted completely the terms, policies, and disclosures listed.

Direct Physical Therapy Treatment Services Disclosure Statement

You are receiving direct physical therapy treatment services from an individual who is a physical therapist (PT) licensed by the Physical Therapy Board of California. Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist. Furthermore, you have the right to obtain physical therapy from a physical therapist of your choice (B&P Code Section 650).

Initials _____

Cancellation/No-Show Policy

To ensure that PT@TheBeach is able to provide the highest quality of care and minimize patient waiting time, 24-hour advanced notification is required for any cancelled appointments. After a single-appointment grace period, a $25 fee will be charged for any no-show or cancellation with less than 24-hours' notice. Three no-shows may result in your discharge from physical therapy, at the discretion of PT@TheBeach.

Initials _____

Authorization to Release or Obtain Health Information

I understand that as part of my health care treatment, PT@TheBeach develops and maintains records containing my health information, which include my health history, symptoms, test results, diagnosis, treatment, and claims and payment history.

1. I hereby authorize a representative of PT@TheBeach to be permitted to review, obtain and release copies of all hospital, medical, vocational, and other related records and to discuss pertinent information with professionals involved in my rehabilitation / physical therapy program.
2. Furthermore, I hereby give permission to PT@TheBeach to share the information received with any institution or designated individual through this authorization to release my records. This includes an insurance program or payment entity paying all or part of the cost of my rehabilitation / physical therapy program. This authorization permits the release of written reports and discussion of the client's condition.

Initials _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.

4. Treatment, payment, eligibility for benefits may not be conditioned upon obtaining this authorization.
5. Information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and is no longer protected by our organization.

Initials _____

Acknowledgment of Notice of Privacy Practices

I have received a copy of the "Notice of Privacy Practices".

Initials _____

Visual/Audio Image Release

I agree and consent to the usage of photographs or videos taken of me by California State University (CSU), for use with my treatment i.e gait or motion analysis. I understand that these images and/or videos will not be used for any other commercial purposes.

Initials _____

Informed Consent

I, the undersigned, hereby give my consent and authorize PT@TheBeach to furnish any medical care and treatment to myself which is considered necessary and proper in diagnosing or treating my physical and mental condition.

I understand that this document is written to be as broad and inclusive as legally permitted by the State of California. I agree that if any portion is held invalid or unenforceable, I will continue to be bound by the remaining terms. I have read this document, and I am signing it freely. No other representations concerning the legal effect of this document have been made to me.

_____	_____	_____
Patient's Name (print)	Patient's Signature	Date

If the Patient is under 18 years of age: *I am the parent or legal guardian of the Patient. I understand the legal consequences of signing this document. I allow the Patient to receive treatment at PT@TheBeach. I understand that I am responsible for the obligations and acts of the Patient as described in this document. I agree to be bound by the terms of this document. I have read this document, and I am signing it freely. No other representations concerning the legal effect of this document have been made to me.*

_____	_____	_____
Patient's Parent/Legal Guardian Name (print)	Patient's Parent/Legal Guardian Signature	Date