



Any previous injury to this area? Y N      Was this a work related injury? Y N      Is case open/closed?  
 Have you had Physical or Speech Therapy this year? Y N With Whom: \_\_\_\_\_  
 Have you had or are you having Home Health? Y N If yes, with whom: \_\_\_\_\_  
 What was Home Health discharge date?: \_\_\_\_\_

**HISTORY**

Do you have/or have you had any of the following:

High Blood Pressure (reading ___/___)	Yes No	Sensitive to ice/heat	Yes No
Heart Disease	Yes No	Allergies	Yes No
Heart Attack	Yes No	Hernia	Yes No
Pacemaker	Yes No	Seizures	Yes No
Diabetes	Yes No	Metal Implants	Yes No
Headaches	Yes No	Dizziness/vertigo	Yes No
Nervous/Psychological Disorder	Yes No	Cancer	Yes No
Hearing Problems	Yes No	Incontinence	Yes No
Asthma/Respiratory Problems	Yes No	Neurological Disorder	Yes No
Tuberculosis (Year _____)	Yes No	Osteoarthritis/Osteoporosis	Yes No
Currently pregnant _____ months	Yes No	Smoker	Yes No
Active Infections _____	Yes No	AIDS	Yes No
		Hepatitis A/B/C	Yes No

Other: \_\_\_\_\_

If yes to any of the above please explain & give approximate date:

\_\_\_\_\_

Past surgeries: \_\_\_\_\_

Medications taken: \_\_\_\_\_

What is your occupation & physical requirements of job: \_\_\_\_\_

Do you have difficulty with any of the following activities? (Check all that apply & specify distance, time, etc. of the limits)

Standing \_\_\_\_\_ Sleeping \_\_\_\_\_ Sitting \_\_\_\_\_  
 Walking \_\_\_\_\_ Driving \_\_\_\_\_ Lifting \_\_\_\_\_  
 Personal Care \_\_\_\_\_ Other \_\_\_\_\_

What benefits do you expect to gain from physical therapy? \_\_\_\_\_

The above information is correct to the best of my knowledge.  
 I have read and fully understand Santa Maria Valley Physical Therapy Group (SMVPT) Notice of Information Practices. I understand that SMVPT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that SMVPT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.  
 I hereby authorize the use and disclosure of my personal health information for purposes as noted in SMVPT Notice of Information Practices. I understand that I retain the right to revoke this authorization by notifying the practice in writing at any time.  
 I hereby authorize my insurance company to pay directly to SMVPT medical benefits otherwise payable to me. I understand that I am responsible for all charges regardless of insurance coverage.  
 I authorize SMVPT to contact former providers of physical therapy for information regarding Medicare payments pertaining to the Medicare cap.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SHORT-FORM MCGILL PAIN QUESTIONNAIRE

Patient name: \_\_\_\_\_

Date: \_\_\_\_\_

	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>
Throbbing	(0) _____	(1) _____	(2) _____	(3) _____
Shooting	(0) _____	(1) _____	(2) _____	(3) _____
Stabbing	(0) _____	(1) _____	(2) _____	(3) _____
Sharp	(0) _____	(1) _____	(2) _____	(3) _____
Cramping	(0) _____	(1) _____	(2) _____	(3) _____
Gnawing	(0) _____	(1) _____	(2) _____	(3) _____
Hot-Burning	(0) _____	(1) _____	(2) _____	(3) _____
Aching	(0) _____	(1) _____	(2) _____	(3) _____
Heavy	(0) _____	(1) _____	(2) _____	(3) _____
Tender	(0) _____	(1) _____	(2) _____	(3) _____
Splitting	(0) _____	(1) _____	(2) _____	(3) _____
Tiring-Exhausting	(0) _____	(1) _____	(2) _____	(3) _____
Sickening	(0) _____	(1) _____	(2) _____	(3) _____
Fearful	(0) _____	(1) _____	(2) _____	(3) _____
Punishing-cruel	(0) _____	(1) _____	(2) _____	(3) _____

A. Please make an "X" on the line below to show how bad your pain is right now.

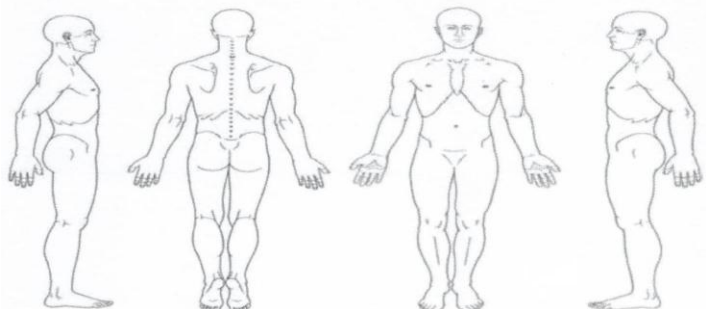
No pain |-----| Worst possible pain

B. Please check the one descriptor that best describes your present pain.

- 0 No pain \_\_\_\_\_
- 1 Mild \_\_\_\_\_
- 2 Discomforting \_\_\_\_\_
- 3 Distressing \_\_\_\_\_
- 4 Horrible \_\_\_\_\_
- 5 Excruciating \_\_\_\_\_

C. Is your pain? (check one word) Brief \_\_\_\_\_ Intermittent \_\_\_\_\_ Continuous \_\_\_\_\_

Please indicate location of pain:



S= \_\_\_ /33 A= \_\_\_ /12



Santa Maria Valley Physical Therapy Group Inc.

**DESIGNATED INDIVIDUALS AUTHORIZATION FORM**

I hereby authorize one or all of the designated parties below to request and receive the release of any protected information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before release of any information.

Authorized Designees:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Name (Print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Todd Martin PT    Jared Bailey PT  
Samantha Stollberg PT, GCS  
Tom Meenzhuber PT    John Hollinshead PT    John Hinds PT  
Karen Bailey PT    Adrian Asencio OT R/L, CHT

## CREDIT CARD PRE AUTHORIZATION FORM

I authorize **SANTA MARIA VALLEY PHYSICAL THERAPY GROUP** to keep on file and to charge my debit/credit card for any services provided to \_\_\_\_\_ as specified below.

Please initial each line showing you have read and understand.

\_\_\_\_ Fees for services not paid by guardian, patient, or patients insurance within 90 days.

\_\_\_\_ Co-pays not paid at the time service was rendered.

\_\_\_\_ Balance of any charges that were not covered by patients insurance.

Name of patient: \_\_\_\_\_

We will bill your insurance as a courtesy to you, however, you are responsible for the total payment regardless of any denial or partial insurance payments.

**Terms of Agreement:** Santa Maria Valley PT Group reserves the right to refuse or terminate your automatic credit card payment services. This agreement is to remain in effect until Santa Maria Valley Physical Therapy Group terminates it or receives written notification of its termination and has sufficient time to act on it.

Patient Name: \_\_\_\_\_

Cardholders Name (as it appears on card): \_\_\_\_\_

Cardholders Billing Address: \_\_\_\_\_

Visa       Mastercard       American Express       Discover Card

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CV#: \_\_\_\_\_