STEP UP
PHYSICAL THERAPY

15750 Northline Road, Suite B
Southgate MI 48195

F: 734-225-6491 P:734-250-8082

Full Name (Print)_____[ ] M [ ] F Date of birth_____

Adresss_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Email_____

Driver License Number_____Social Security number_____

Referring Doctor Name:_____Referring Doctor Number:_____

Family Doctor Name:_____Family Doctor Number:_____

Emergency Contact
Name:_____ Phone:_____
Relationship:_____

Name:_____ Phone:_____
Relationship:_____

Employment
Current status [ ] Working [ ] Not working
Employer:_____
Insurance
Primary Insurance_____Contract#_____Group#_____
Subscribers Name_____DOB of subscriber_____
Are you covered by secondary insurance: [ ] Yes [ ] N
SecondaryInsurance_____Contract#_____Group#_____
Subscriber name_____DOB of subscriber_____

Automobile/motor cycle insurance coverage
Is this Injury covered by an automobile accident insurance? [ ] Yes [ ] No [ ]Not applicable (skip below)
Date of accident_____Claim#_____ Insurance Carrier_____
Carrier Address_____
Name of Insured_____Adjustor_____Adjustor Phone_____
Workers Compensation
Is this injury covered by Workers Compensation? [ ] Yes [ ] No [ ] Not Applicable (skip below)
Insurance Carrier_____Carrier Address_____
Adjustor_____Adjustor phone_____
Do you have an attorney for this injury/claim? [ ] Yes [ ] No
Name_____Address_____

How did you hear about us?

MD ☐ | Instagram ☐ | Facebook ☐ | Friend ☐ | Website ☐ | Promo ☐ | Staff ☐ | Other:

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Physical Therapy Admission Information Sheet

Name:_____
____
Height_____ **Weight**_____ **Age**_____
Are you [ ] Right Handed [ ] Left Handed

Injury History
Date of Injury Onset:
Is this a Work Related Injury? [ ]Yes [ ] No

Where do you Live?
____ One level home
____ Mobil Home
____ Assisted Living
____ Long Term Care
_____ 2 level home
_____ Apartment
_____ Multi Level Home

With whom do you live?
[ ]Alone [ ]Parents
[ ]Spouse [ ]Spouse and children
[ ] Group setting

Do you use:
[ ] Cane [ ] Manual Wheelchair
[ ] Walker [ ] Motorized Wheelchair

Health Habits:
Do you use tobacco? [ ] Yes [ ] No How many packs per day_____
Do you drink alcohol? [ ] Yes [ ] No How much do you drink per day_____
Do you exercise regularly? [ ] Yes [ ] No
If yes, how often and what type of activities?_____

Have you fallen 1 or more times in the last year? [ ]Yes [ ] No

Have you had Physical Therapy, Home Health or Chiropractic care this year? [ ]Yes [ ] No

If yes, when:

Any Medication allergies:[ ]Yes [ ] No

If yes:

_____

_____

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Are you currently taking any medications? [ ] Yes [ ]No

CURRENT MEDICATIONS: Please list all of your medications

Name of Medication	Dose	Regimen
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PAST MEDICAL HISTORY: Select all that apply, unchecked box indicates negative

Anesthesia:	Cardiovascular:	Pulmonary:	Neurological:
[ ] Difficult Intubation	[ ] Angina	[ ] Asthma	[ ] Anxiety
[ ] Malignant Hyperthermia	[ ] CHF	[ ] COPD	[ ] Bipolar Disorder
Hepatic/Renal:	[ ] Coronary Artery Disease	[ ] Pulmonary Fibrosis	[ ] Depression
[ ] Cholelithiasis	[ ] Dysrhythmia	[ ] Tuberculosis	[ ] Neuropathy
[ ] Cirrhosis	[ ] Heart Murmur	Endocrine:	[ ] Schizoaffective Disorder
[ ] Jaundice	[ ] Hyperlipidemia	[ ] Diabetes Type 1	[ ] Seizures
[ ] Kidney Disease	[ ] Hypertension	[ ] Diabetes Type 2	[ ] Stroke
[ ] Kidney Stones	[ ] Myocardial Infarction	[ ] Hyperthyroidism	[ ] TIA
[ ] Liver Disease	Gastrointestinal:	[ ] Hypothyroidism	Hematologic:
[ ] Pancreatitis	[ ] Colon Cancer	Other:	[ ] Anemia
[ ] Renal Insufficiency	[ ] Esophageal Cancer	_____	[ ] Blood Transfusion Reaction
[ ] Viral Hepatitis	[ ] GI Ulcer	_____	
	[ ] Hiatal Hernia	_____	[ ] Clotting Disorder
	[ ] Inflammatory Bowel	_____	

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History of current problem(s):

When did the problem(s) being? ------/---------/---------

Explain:_____

_____

_____

_____

_____

Have you had any X-rays Cat Scan, MRI's or other diagnostic tests for your recent disorder?
Yes No

If yes, please explain the finding as you understand them:_____

_____

_____

_____

_____

_____

What activities are you not able to do now that you could do before the current problem(s)?

_____

_____

_____

_____

_____

What are your goals for Physical Therapy?

_____

_____

_____

_____

_____

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Pain Rating

I would **currently** rate my pain as:

No Pain		Weak Pain		Moderate Pain		Strong	Very Strong		Very, very Strong	Emergency
0	1	2	3	4	5	6	7	8	9	10

The **least** amount of pain I have had in the **last 30 days** is:

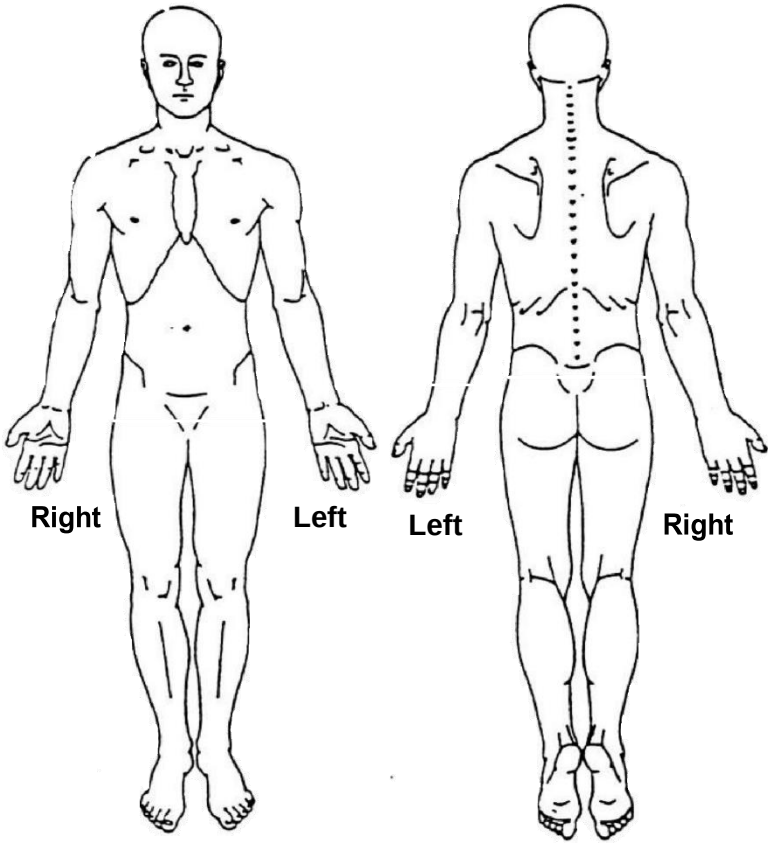
No Pain		Weak Pain		Moderate Pain		Strong	Very Strong		Very, very Strong	Emergency
0	1	2	3	4	5	6	7	8	9	10

The **worst** amount of pain I have had in the **last 30 days** is:

No Pain		Weak Pain		Moderate Pain		Strong	Very Strong		Very, very Strong	Emergency
0	1	2	3	4	5	6	7	8	9	10

Pain Drawing

Please shade all areas of discomfortcaused by your current injury.



Since your injury condition began, your symptoms are ?

[ ] Better [ ] Same [ ] Worse

Over a full day how often you have symptoms?

[ ]Occasional	[ ] Intermittent	[ ] Frequent	[ ] Constant
10-25 %	26-50%	51-80%	81-100%

How is your sleep?

[ ] Good	**[ ]Moderate**	**[ ] Difficult**	**[ ] With Medications**
Position	**[ ] Back**	**[ ] Side**	**[ ] Stomach**

Pain quality: [ ]aching [ ]burning [ ]cramping [ ]shooting [ ]stabbing [ ]other_____

What makes your injury feel Better (B), Same (S), or Worse (W)? Check each column.

Action	B	S	W	Action	B	S	W
Nothing				Twisting			
Sitting				Laying down			
Standing				Sleeping			
Walking				Rest			
Running				Sneezing			
Movement				Coughing			
Bending				Medication			
Exercise				Writing			
Kneeling				Computer			
Lifting				Other:			
Stairs							

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PATIENT FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Patient Name: Date:

INSTRUCTIONS: Circle the level of difficulty for each activity.			0 = Absolute no difficulty	1 = Able to do with little difficulty	2 = Able to do w litmod difficulty	3 = Able to do w mod difficulty	4 = Able to do w modsignif difficulty	5 = Able to do w signif difficulty	6 = Unable to do at all	Not applicable
MOBILITY/WALKING	1	Walking short distances	0	1	2	3	4	5	6	n/a
	2	Walking long distances	0	1	2	3	4	5	6	n/a
	3	Walking outdoors	0	1	2	3	4	5	6	n/a
	4	Climbing stairs	0	1	2	3	4	5	6	n/a
	5	Hopping	0	1	2	3	4	5	6	n/a
	6	Running	0	1	2	3	4	5	6	n/a
CHANGE/MAINTAIN BODY POSITION	1	Rolling over	0	1	2	3	4	5	6	n/a
	2	Moving - lying to sitting	0	1	2	3	4	5	6	n/a
	3	Sitting	0	1	2	3	4	5	6	n/a
	4	Bending/Stooping	0	1	2	3	4	5	6	n/a
	5	Kneeling	0	1	2	3	4	5	6	n/a
	6	Standing	0	1	2	3	4	5	6	n/a
CARRY/MOVE/ HANDLE OBJECTS	1	Pushing	0	1	2	3	4	5	6	n/a
	2	Pulling	0	1	2	3	4	5	6	n/a
	3	Reaching	0	1	2	3	4	5	6	n/a
	4	Grasping	0	1	2	3	4	5	6	n/a
	5	Lifting	0	1	2	3	4	5	6	n/a
	6	Carrying	0	1	2	3	4	5	6	n/a
SELF CARE	1	Dressing/Clasp b/h back	0	1	2	3	4	5	6	n/a
	2	Doing light housework	0	1	2	3	4	5	6	n/a
	3	Prep meals/kitchen tasks	0	1	2	3	4	5	6	n/a
	4	Bathroom activities	0	1	2	3	4	5	6	n/a
	5	Sleeping Ability	0	1	2	3	4	5	6	n/a
	6	Hygiene (comb hair/brush teeth)	0	1	2	3	4	5	6	n/a

PATIENT SIGNATURE **DATE**

REVIEWED BY THERAPIST / CREDENTIALS **DATE**

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CONSENT TO TREATMENT

I consent to rehabilitation and related services at: Step Up Physical Therapy.

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. Initials:_____

LIABILITY

I know and agree that: STEP UP PHYSICAL THERAPY is not responsible for loss or damage to personal valuables.

Initials:_____

WAIVER AND RELEASE

I hereby release, discharge and acquit: STEP UP PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. Initials:_____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. To assist in establishing your account, please: - Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information. - Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered. - Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.

Initials:_____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: STEP UP PHYSICAL THERAPY

I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. Initials:_____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practice

I acknowledge receipt of the Statement of Patient Rights. Initials:_____

I certify that all of the information provided herein is true and correct

Patient/Guardian Signature: _____

Witness Signature: _____

Date:_____