LEISURE PHYSICAL THERAPY QUESTIONNAIRE

NAME: _____ DOB: _____

ADDRESS: _____

EMAIL: _____

HOW DID YOU HEAR ABOUT LEISURE PHYSICAL THERAPY? _____

HOME PHONE: _____ CELL PHONE: _____

PRIMARY INS: _____ INS. ID#: _____

SECONDARY INS: _____INS. ID #: _____

DIAGNOSIS: _____

WHAT ARE YOU HAVING A HARD TIME WITH AS A RESULT OF YOUR CONDITION:

1. _____
2. _____
3. _____

WHEN DID IT YOUR PROBLEM START? _____

HOW DID IT HAPPEN? _____

ARE THERE ANY HEALTH ISSUES OR OTHER THINGS THAT COULD INTERFERE WITH YOU GETTING BETTER:_____

WHAT TESTS HAVE BEEN DONE FOR YOUR CONDITION? _____

NAME ALL HEALTH PROFESSIONALS SEEN FOR THIS CONDIITON: _____

_____

HAVE YOU RECEIVED PT FOR THIS CONDITION IN THE PAST? YES NO (CIRCLE ONE)

DID IT HELP? YES NO (CIRCLE ONE)

WHAT OBSTACLES ARE IN THE HOME (IE. STAIRS, ETC) _____

OCCUPATION: _____ HAVE YOU FALLEN IN THE PAST 12 MONTHS? YES/NO

VISION: (CIRCLE ONE) FUNCTIONAL WELL/NOT FUNCTIONING WELL HEIGHT: _____
WEIGHT: _____ DO YOU LIVE ALONE? YES/NO

YOUR SYMPTOMS (CIRCLE ONE): MILD MODERATE SEVERE

LOCATION OF PAIN: _____

DESCRIPTION: (CIRCLE ONE) SHARP/ACHY/ELECTRIC/BURNING/DULL/STABBING/OTHER

PAIN SCALE: (CIRCLE ONE: 0 NO PAIN 10 WORST PAIN) RIGHT NOW: 0 1 2 3 4 5 6 7 8 9 10

AT ITS WORST: 0 1 2 3 4 5 6 7 8 9 10; AT ITS BEST 0 1 2 3 4 5 6 7 8 9 10

MEDICATION LIST (REQUIRED BY CMS)

1. _____
2. _____
3. _____
4. _____
5. _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?

YES/NO	CANCER	YES/NO	COPD
YES/NO	HIGH BLOOD PRESSURE	YES/NO	HAND PAIN
YES/NO	BYPASS	YES/NO	PARKINSON'S
YES/NO	HEART ATTACK	YES/NO	SEIZURES
YES/NO	ARTHRITIS	YES/NO	FRACTURES
YES/NO	STROKE, TIA	YES/NO	JOINT REPLACEMENTS
YES/NO	DIABETES	YES/NO	BALANCE PROBLEMS
YES/NO	PACEMAKER DEFRIB	YES/NO	DEPRESSION
YES/NO	KIDNEY DISEASE	YES/NO	LOW BACK PAIN
YES/NO	ASTHMA	YES/NO	DIZZINESS

PLEASE LIST ANY SURGERIES OR OTHER MEDICAL CONDITIONS YOU HAVE BEEN HOSPITALIZED FOR, INCLUDING THE APPROXIMATE DATE:

_____

_____

HAVE YOU RECENTLY NOTED

YES/NO	WEIGHT LOSS/GAIN	YES/NO	WEAKNESS
YES/NO	NAUSEA/VOMITING	YES/NO	FEVER/CHILLS/SWEATS
YES/NO	FATIGUE	YES/NO	NUMBNESS OR TINGLING
YES/NO	LOSS OF BOWEL	YES/NO	LEGS GIVING OUT
YES/NO	LOSS OF BLADDER		

DO YOU HAVE ANY OTHER PROBLEMS BESIDES YOUR CURRENT COMPLAINT?

CIRCLE ALL THAT APPLY: **BACK, NECK, HIP, KNEE, ANKLE, BALANCE, TMJ, SHOULDER, ELBOW, WRIST, HAND, DIZZINESS**

Patients Name: _____

Welcome to Leisure Physical Therapy. As a courtesy, we will try to get the most accurate insurance Information regarding your Physical Therapy benefits. However, we may not be given complete or proper information from your insurance company. It is your responsibility to Know your Physical Therapy Benefits and limits available to you according to your policy as well as any financial responsibility required of you for our services.
AT TIMES THE INSURACE COMPANY GIVES US WRONG INFORMATION.
YOU ARE STILL RESPONSIBLE FOR PAYMENT.

It is also your responsibility to give us accurate and updated information. Any services denied due to no insurance coverage or giving us inaccurate insurance coverage will be your full financial responsibility.

CANCELLATIONS POLICY:

We require a 24hr notice in the event of cancellation. We also reserve the right to charge a **$10.00** fee to those who call to cancel without a 24 hr. notice. If you reschedule during that week you will not be charged.

NOTICE OF PRIVACY PRACTICES:

Patient acknowledgment of receipt. This is to acknowledge that I have received and reviewed Leisure Physical Therapy Notice of Privacy. Should I have any questions regarding the notice of privacy practices, I understand that I can contact Leisure Physical Therapy at 631-821-8090

AUTHORIZATION TO BILL INSURANCE COMPANY:

I hereby authorize Leisure Physical Therapy to furnish information to my insurance company concerning my illness and treatments and I hereby assign any payments to Leisure Physical Therapy rendered for physical therapy services. In the event the providers charges are outstanding, or I fail to provide the office with accurate insurance information, I understand I am personally responsible for payment of the charges.

By Signing I agree to the above:

Signature of Patient: _____ Date Signed: _____

Non-covered services by insurance:

We apologize for the inconvenience but some things we do are not covered under insurance. We want to be as upfront as possible so there are no hidden expenses. Your therapist will only recommend what they feel is necessary but it is your right to refuse treatment.

Kinesiotape: $12 for 1 body par for duration of PT; $20 if taping 2 body parts for duration of PT

Laser: $330 for package of 6 visits
After first 6 visits, can purchase in package of 3 for $165

Heel Lifts: $12.50 each

Orthotics: $298 for first pair
$200 for second pair

Pulleys: $20

Estim Pads $5 (2 pads) these are kept here with your name on them

Lumbar Roll: $20

TENS Units: $40

Walker Coasters: $15 for one pair

Please sign to acknowledge we provided you this information. You are not signing to purchase anything.

Patient Signature: _____