

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: Attorney/Payment (per visit): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **DATE** | **SIGNATURE** |  | **DATE** | **SIGNATURE** |  | **DATE** | **SIGNATURE** |
| 1 |  |  | 15 |  |  | 29 |  |  |
| 2 |  |  | 16 |  |  | 30 |  |  |
| 3 |  |  | 17 |  |  | 31 |  |  |
| 4 |  |  | 18 |  |  | 32 |  |  |
| 5 |  |  | 19 |  |  | 33 |  |  |
| 6 |  |  | 20 |  |  | 34 |  |  |
| 7 |  |  | 21 |  |  | 35 |  |  |
| 8 |  |  | 22 |  |  | 36 |  |  |
| 9 |  |  | 23 |  |  | 37 |  |  |
| 10 |  |  | 24 |  |  | 38 |  |  |
| 11 |  |  | 25 |  |  | 39 |  |  |
| 12 |  |  | 26 |  |  | 40 |  |  |
| 13 |  |  | 27 |  |  | 41 |  |  |
| 14 |  |  | 28 |  |  | 42 |  |  |

**PATIENT INFORMATION**

Name Last:

First:

M.I.:

SSN:

Address:

City:

State:

Zip:

Home Phone:

Cell Phone:

Email:

Preferred Method of Appt Reminders: [ ] Home Phone [ ] Cell Phone [ ] Text [ ] Email [ ] Check Here For No Appt Reminder

How Did You Hear About Us: [ ] Doctor [ ] Attorney [ ] Hospital [ ] Friend [ ] TV [ ] Radio [ ] Internet [ ] Insurance

Date of Birth:

Gender:

Date of Injury:

Place (State) of Injury:

Emergency Contact:

Relationship:

Phone:

( )

**PATIENT INSURANCE INFORMATION - PLEASE BRING YOUR INSURANCE CARD**

**Primary Insurance Company:**

ID #:

Name of Subscriber:

Date of Birth:

Group #:

Relationship to Subscriber: (Circle One) Self / Spouse / Minor / Other

Employer:

Work Phone:

**Secondary Insurance Company (If Applicable):**

ID #:

Name of Subscriber:

Date of Birth:

Group #:

Relationship to Subscriber: (Circle One) Self / Spouse / Minor / Other

Employer:

Work Phone:

Name Last:

First:

M.I.:

SSN:

Address:

City:

State:

Zip:

Relationship to Subscriber: (Circle One) Self / Spouse / Other

Date of Birth:

Employer:

Work Phone:

**GUARDIAN INFORMATION (IF UNDER 18 YEARS OLD)**

**CONSENT FOR TREATMENT**

**Consent for Treatment:** I understand I have the right to choose my physical therapy provider and have chosen Physical Therapy Now and hereby authorize and give my consent for PT Now to furnish physical therapy care and treatment deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment.

**Consent for Treatment of a Minor:** As parent and/or legal guardian, I authorize and give my consent for Physical Therapy Now

to treat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (minor's name) while I am not present.

**Patient / Guardian / Responsible Party Signature:**

**Date:**

**Physical Therapy Now  
REGISTRATION FORM**

**Patient Signature:**

**Date:**

**Parent / Guardian / Guarantor:**

**Date:**

**PATIENT AUTHORIZATION**

- By my initials and signature, I understand these policies and my financial obligations for services rendered.

- I hereby assign payment of benefits by my insurance company to Physical Therapy Now, and I accept responsibility to ensure my insurance carrier makes payment on my account within 90 days. Lack of payment by my insurance carrier will result in all charges being transferred to my personal balance on my statement.

- I hereby agree to pay any office visit/co-payment charges at time of visit.

- I hereby agree to promptly pay my personal account balance including co-insurance or unmet deductible upon receipt of my statement. I understand and agree that responsibility for payment for services rendered is mine, due and payable unless other financial arrangements have been made. In the event of default, I agree to pay such collection costs and reasonable attorney fees as may be required to effectively collect the debt.

**OFFICE POLICY AND FINANCIAL RESPONSIBILITY**

**PATIENT INFORMATION CONSENT:** I have read and fully understand Physical Therapy Now's Notice of Information Practices. I understand that PT Now 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 by notifying the practice. I also understand that Physical Therapy Now will consider requests for restriction on a case by case basis but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Physical Therapy Now's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

**Initials**

**Initials**

**ATTENDANCE, CANCELLATION, and NO SHOW:** Attendance at your therapy visits is your most important responsibility because it can make the difference between whether or not you succeed in your treatment. While we understand you may need to cancel an appointment because of unforeseen circumstances, we do require at least 24 hour’s notice of cancellation. There is a $25 charge for cancellation without prior notice or for not showing for your appointment. This charge is not covered by insurance, and you are required to pay this fee personally.

**FINANCIAL RESPONSIBILITY:** As a courtesy to you, Physical Therapy Now will file your medical insurance claims. The contract between you as a patient and your insurance company is, however, personal to you. PT Now is not responsible for issues between the patient and insurance carrier, nor can PT Now intervene or negotiate for either party on disputed claims. Please advise us immediately if you change insurance coverage while undergoing treatment. Physical therapy equipment and/or supplies are typically not reimbursable by the insurance carrier. As such, PT Now requires payment by the patient for any equipment/supply at the time the order is placed. HOT will provide a receipt as documentation of the purchase so you may pursue reimbursement personally. PT Now accepts cash, visa, MasterCard, or discover as payment options.

**Initials**

**CONSENT TO CONFIDENTIAL MEDICAL INFORMATION**

I hereby authorize PT Now to share any and all of my medical / billing information with the following people:

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

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

Physical Therapy Now

**HIPAA Privacy Role Patient Consent and Acknowledgment**

I consent to the use or disclosure of my protected health information by Physical Therapy NOW LLC; for the purpose of providing me with health care treatment, getting paid for those services and conducting the health care operation portion of its business. I also acknowledge that I received and read the Physical Therapy NOW LLC Notice of Privacy Practices.

I understand the following:

* “My protected health information” means my health-related information either collected from me or received by Physical Therapy NOW LLC, from any other source, and it includes information about my past, present and future physical or mental health.
* If I refuse to sign this consent and acknowledgement, Physical Therapy NOW LLC has the right to refuse me as the patient.
* I have the right to ask Physical Therapy NOW LLC in writing, to limit the way in which it uses or discloses my protected health information, but Physical Therapy NOW LLC does not have to agree to my request. However, if Physical Therapy NOW LLC does agree, then it is bound by that agreement.

I have the right to revoke the Consent portion of this document at any time by providing

* Physical Therapy NOW LLC with a written request specifically stating my desire to revoke my consent to use of the PHI. Physical Therapy NOW LLC must accept this revocation but then may refuse to provide me with further heath care treatment.
* If I revoke the Consent portion of this document, it is effective, except the extent that Physical Therapy NOW LLC, has already used or disclosed my protested health information in reliance on this consent.

Before I signed this Consent and Acknowledgement, I reviewed Physical Therapy NOW LLC, Notice of Privacy Practices, and understand the following with respect to the Notice:

* Physical Therapy NOW LLC has the right to change the terms of the Notice at any time but if it does, it must post the new Notice in the waiting room and give me a copy if I request one.
* The Notice describes in detail, the types of uses and disclosures of my protected health information that Physical Therapy NOW LLC may make in treating me, getting paid for that treatment or in carrying out its health care operations.

I have read and understand this information and have received a copy of this Consent and Acknowledgement. I am the patient, or I am authorized to act on behalf of the patient for the reason described below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_

Patient or Personal Representative Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Signatory

**ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND**

***Insurer and Patient Please Read the Following in its Entirely Carefully!***

I, the undersigned patient/insured knowingly, voluntarily, and intentionally assign the rights and benefits of my automobile insurance,

also known as Personal Injury Protection (hereinafter PIP), and Medical Payments policy of insurance to the above health care

provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time

services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the

insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider’s bills are paid or

applied to a deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits

includes the cost of transportation, medications, supplies, overdue interest, and a potential claim for common law or statutory bad

faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to notify the

provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to

contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without reductions and

without including the patient’s name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the

application for the insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured

under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to the file

suit for recover of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical

bills do not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the

difference between the medical bills and the premiums paid. The insurer is directed by the provider and the undersigned to not issue any

checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from

liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the

insurance policy. The insured and the provider hereby contest and objects to any reductions or partial payments. Any partial or reduced

payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the

risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement, or agreement by the provider to

accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full

amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath (hereinafter “EUO”) the insurer is hereby INSTRUCTED to send

a copy of said notification to this provider. The provider or the provider’s attorney is expressly authorized to appear at any EUO or IME

set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both

past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original.

I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other

services unrelated to the automobile accident. The health care provider is given the power of attorney to endorse my name on any check

for services rendered by the above provider, and to request and obtain a copy of any statements or examinations under oath given by patient.

***Release of Information:*** I hereby authorize this provider to: furnish an insurer, an insurer’s intermediary, the patient’s other medical

providers, and the patient’s attorney via mail, fax, or email, with any and all information that may be contained in the medical records

to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer, request

from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal

statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not

limited to, documents, reports, scans, notes, bills, Opinions, X-Rays, IMEs, and MRIs, from any other medical provider or any insurer. The

provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep

the patient’s medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to

anyone without the patients and the provider’s prior express written permission.

***Demand:*** Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP

payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in

the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day

the insurer is directed to not apply this provider’s bill to the deductible. If a bill from this provider and claim from anyone else is received by

the insurer on the same day then insurer is directed to pay this provider first before the policy is exhausted. In the event of the provider’s

medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to; set aside the entire amount disputed or

reduced; escrow the fill amount at issue; and most pay the disputed amount to anyone or any entity, including myself, until the dispute is

resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

***Certification:*** I certify that; I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health

care: I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I

agree the provider’s prices for medical services, treatment and supplies are reasonable, usually, and customary.

***Caution:*** Please read before singing. Please ask to view a copy of our charges. If you do not completely understand this document, please ask

us to explain it to you. If you sign below, we will assume you understand and agree to the above.

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Patient’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_

**Letter of Protection**

**Patient Name:**

I do hereby authorize the above center to furnish you, my attorney with a full report of my case history, examinations, diagnosis, treatment, and prognosis of myself regarding my accident / injury which occurred on / / .

I hereby give a lien to said physician on any settlement, claims, judgment, or verdict as a result of said accident / injury and to authorize you, my attorney to pay directly to the doctor such sums as may be due and owing them for services rendered me, and to withhold such sums from settlement claim, judgment or verdict as may be necessary to protect said physician.

I fully understand that I am solely responsible to said doctor for all bills submitted by them for services rendered me, and that this agreement is made solely for said physician’s additional protection and in consideration for his awaiting payment.

I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

I understand that at anytime I may inquire as to the charges and payments on my account and that this information will be given in full, in writing within 5 business days.

Dated: / / Patient’s Signature:

The undersigned being attorney of record, or duly authorized representative of the attorney, for the above-named patient does hereby acknowledge receipt of the above lien.

Who does agree to honor the same to protect adequately said physician.

/ /

Dated Attorney Signature

Printed Attorney Name

**Physical Therapy Now Financial Policy**

**Patient:**

**ID #:**

**Primary Insurance:**

We have verified your insurance coverage and benefits as of . This information is being provided to you exactly as it was told to us. Please INITIAL Highlighted Benefits Related to Your Policy.

You do not have a co-pay associated with your primary insurance.

Yes or No If Yes how much $\_\_\_\_\_\_\_\_\_\_

You do not have a deductible associated with your primary insurance.

Yes or No If Yes how much $\_\_\_\_\_\_\_\_\_\_

You do not have a coinsurance associated with your primary insurance.

Yes or No If Yes how much $\_\_\_\_\_\_\_\_\_\_

You do not have a secondary insurance.

Yes or No If Yes name of secondary insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We accept Cash, Personal Checks, and Credit Cards (MASTERCARD, VISA, AND DISCOVER).

If there are concerns regarding your financial responsibility for this service, please ask the Front Office to speak with our Billing Department or contact them directly at 305-244-5883 to discuss your situation if needed.

Please be aware that your benefits and/or coverage information may be subject to errors. Therefore, we strongly recommend you contact your insurance directly if you have any questions or concerns regarding this benefit.

**CONSENT: I understand these benefits as explained to me.**

**Patient**

**Signature:**

**PT Now Employee   
 Signature:**

**Date:**

**Date:**











\_\_\_\_\_\_\_\_\_\_

**REHABILITATION MEDICAL HISTORY QUESTIONARY**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

D.O.B: \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Serious illness/Surgery/Hospitalization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you evaluated by Fire Rescue? (Circle one) YES or NO

Were you transported to hospital? (Circle one) YES or NO If yes which hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Current Medical & Health Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel limited in what you are able to do due to your present condition? If yes, How? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel sad, rejected, or depressed about your current conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had problem, in the present or past, with any of the following conditions?

Yes\_\_\_ No \_\_\_ Diabetes

Yes \_\_\_ No \_\_\_ Hypertension

Yes \_\_\_ No \_\_\_ Low Blood Pressure

Yes \_\_\_ No\_\_\_ Sad/Depressed with your Physical problem.

Yes \_\_\_ No\_\_\_ Heart Conditions (Arrhythmias, Murmur, Stent, CAD)

Yes \_\_\_ No \_\_\_ Pacemaker

Yes \_\_\_ No \_\_\_ Circulatory Deficit

Yes \_\_\_ No \_\_\_ Anxiety/ Nervousness

Yes \_\_\_ No \_\_\_ Allergies

Yes \_\_\_ No \_\_\_ Cancer History (self)

Yes \_\_\_ No \_\_\_ Drug/ Alcohol Abuse

Yes \_\_\_ No \_\_\_ Self Isolation

Yes \_\_\_ No \_\_\_ Loss of appetite

Yes \_\_\_ No \_\_\_ Worry about present health

Yes \_\_\_ No \_\_\_ Self-care Difficult

Yes \_\_\_ No \_\_\_ Liver disease

Yes \_\_\_ No \_\_\_ Kidney disease

Yes \_\_\_ No \_\_\_ Immune System

Yes \_\_\_ No \_\_\_ Anxiety over potential for recuperation

Yes \_\_\_ No \_\_\_ Lung/ Breathing difficult/ SOB

Yes \_\_\_ No \_\_\_ Seizures

Yes \_\_\_ No \_\_\_ Stroke

Yes \_\_\_ No \_\_\_ GI/ Gastrointestinal / Diverticulitis

Yes \_\_\_ No \_\_\_ Urinary / Prostate

Yes \_\_\_ No \_\_\_ Anemia

Yes \_\_\_ No \_\_\_ Arthritis / Osteoporosis / Osteopenia

Yes \_\_\_ No \_\_\_Insomnia

Yes \_\_\_ No \_\_\_ Weight loss/ gain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

Patient’s Signature Date

**Duties Performed Under Duress at Work and Home**

Patient name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury \_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_

Initial Update

**Please check all that apply to your WORK because of the accident**

|  |  |
| --- | --- |
| I go to work but work in pain  I limit my work activities  Bending at work hurts  Stooping at work hurts  Sitting at work hurts  Using the computer at work hurts  Pushing at work hurts  Kneeling at work hurts  I have lost status in my company  I have lost job security  I did not get a promotion  I do not enjoy work as much as before  I doze off at work  I take unpaid time off work to go to Dr.  I daydream at work more than before  I feel tired at work  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | I work in pain because I have bills to pay  I cannot take time off because I would lose my job  I keep working so I do not lose status at company  My business would fail if I took time off  I believe in working even when I am in pain  I feel obligated to work even though I am in pain  My business would lose money if I took time off  My work is not as good as it was before accident  My boss reprimanded me for poor performance  I got a different job within the same company  I got a different job in another company  I make less money than before the accident  I cannot do the same work/job as before accident  I cannot concentrate as well at work  I take paid time off to go to Dr.  I make mistakes at work I did not use to  I hide my poor work performance from my boss  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please check all that apply to your HOME/DOMESTIC because of the accident**

|  |  |
| --- | --- |
| My house is not as clean now  My yard is not as neat now  My garden is not as productive now  I do yard work, but do it in pain  I cannot do my normal yard work  I do housework, but do it in pain  I cannot do my normal housework  Doing laundry hurts me  I cannot do laundry now  Washing dishes hurts me  I cannot vacuum now  Cooking hurts me  I cannot cook now  Washing the car hurts me  I cannot wash my car  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | I cannot take time off because I care for children  I have \_\_\_\_\_\_\_\_children ages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I had to hire a paid housekeeper  I asked someone for unpaid housekeeping help  I had to hire a paid gardener  I asked someone for unpaid yard work help  Mowing the lawn hurts me  I cannot mow the lawn  Taking out the trash hurts me  I cannot take out the trash  I do not enjoy my gardening/yardwork like I used to  I do not enjoy my housework like I used to  Gardening hurts me  I cannot do my gardening at all since the accident  Others living with me do my share of the work now  Others living with me do my share of the yard now  Others living with me do my share of the gardening  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

**Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School (1 of 2 pages)**

Patient’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date\_\_\_\_\_\_\_\_\_\_\_\_

Initial Update

**Please check all that apply to your EXERCISE & SPORTS Activity because of the accident**

|  |  |
| --- | --- |
| My exercise was affected by this crash  I go to the gym & work out in pain  I no longer go to the gym to work out  I run but in pain  I no longer run  I take walks & have pain while walking  I no longer take walks  I used to make income at sports  I have lost sports income since crash  I am an amateur athlete  I am a professional athlete  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | I have gained\_\_\_\_\_\_ pounds since the accident  I had to quit my \_\_\_\_\_\_\_ team after the accident  I had to quit my \_\_\_\_\_\_\_team after the accident  I had to quit my \_\_\_\_\_\_\_team after the accident  I had to quit my \_\_\_\_\_\_\_team after the accident  I do not enjoy the sport of \_\_\_\_\_\_\_\_\_\_\_anymore  I did not enjoy the sport of \_\_\_\_\_\_for \_\_\_\_weeks  I do not enjoy the sport of \_\_\_\_\_\_\_\_\_\_\_anymore  I did not enjoy the sport of \_\_\_\_\_\_for \_\_\_\_weeks  I do not enjoy the sport of \_\_\_\_\_\_\_\_\_\_\_anymore  I did not enjoy the sport of \_\_\_\_\_\_for \_\_\_\_weeks  I do not enjoy the sport of \_\_\_\_\_\_\_\_\_\_\_anymore  I did not enjoy the sport of \_\_\_\_\_\_for \_\_\_\_weeks |

**Please check all that apply to your HOBBY Activities because of the accident**

|  |  |
| --- | --- |
| My hobbies were affected by accident  Hobby #1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I cannot do hobby #1 anymore  I do hobby #1 but in pain  I have lost money from not doing #1  I did not do hobby #1 for \_\_\_\_\_\_ weeks  Hobby #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I cannot do hobby #2 anymore  I do hobby #2 but in pain  I have lost money from not doing #2  I did not do hobby #2 for \_\_\_\_\_\_ weeks | Hobby #3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I cannot do hobby #3 anymore  I do hobby #3 but in pain  I have lost money from not doing #3  I did not do hobby #3 for \_\_\_\_\_\_ weeks  Hobby #4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I cannot do hobby #4 anymore  I do hobby #4 but in pain  I have lost money from not doing #4  I did not do hobby #4 for \_\_\_\_\_\_ weeks  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please check all that apply to your TRAVEL Activities because of the accident**

|  |  |
| --- | --- |
| Business travel was affected by crash  Pleasure travel was affected by crash  I hurt driving in my own car  I am in too much pain to drive  I hurt when a passenger in a car  I am in too much pain to sit in a car  I have anxiety when I am in a car  I hurt when I am on an airplane  I am in too much pain too much pain to travel by plane | Travel Plan #1  I did not go on travel plan #1  I went, but did not enjoy #1 as much  I went and the accident had no effect on #1  Travel Plan #2  I did not go on travel plan #2  I went, but did not enjoy #2 as much  I went and the accident had no effect on #2  I missed time with my family/friends b/c cannot travel |

**Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School (2 of 2 pages)**

Patient’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date\_\_\_\_\_\_\_\_\_\_\_\_

Initial Update

**Please check all the DAILY LIVING activities that cause you pain because of the accident**

|  |  |
| --- | --- |
| Dressing  Putting on pants  Putting on shoes  Tying my shoes  Putting on shirt  Drying my hair  Combing my hair  Washing my hair  Taking a shower  Taking a bath  Leaning forward  Lying in bed  Sitting in my favorite chair  Sleeping  Going out with my friends  Sitting at a restaurant  Shopping  Driving to/from work  Sitting in Church  Playing with my children  Caring for my children  Bending in a movie theatre  Sitting in a movie theatre  Exercise  Eating  Stooping  Squatting down  Kneeling  Brushing my teeth | Riding in a car  Opening a jar  Lifting a pan when cooking  Closing the trunk on my car  Opening the garage door  Using my home computer  Climbing stairs  Sexual activity  Turning my head to left or right  Holding my head up all day  Watching TV  I have pain sitting & doing nothing  Talking on the phone  Reading  Writing  Opening doors  Drying with a towel after a bath or shower  Life has become a chore just to do normal things  It is depressing to live like this  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident**

|  |  |
| --- | --- |
| School was affected by the accident  I am a student at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I am in the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year/grade  I was full-time part time  I am now full-time part time  I had to take fewer classes b/c of crash  I missed \_\_\_\_\_\_\_\_ days of school  I had to drop out of school b/c of crash  My grades are lower since the crash | I have pain carrying my schoolbooks  I hurt sitting in class more than \_\_\_\_\_\_ minutes  My neck hurts when I look down to read  I do not learn as quickly as before the crash  I do not learn things as well as before the crash  I have difficulty concentrating in class  It takes much longer to study/do my homework  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date





