Tewksbury Physical Therapy, 885 Main Street, Unit 4, Tewksbury, MA 01876

Name: _____ Date of Birth:_____ Age_____

Address:_____ S.S. #_____-_____-_____
(No. & street)

_____ Occupation:_____
(city or town) (state) (zip code)

Telephone: Home: (_____)_____ Work: (_____)_____ Cell Phone (____)_____

Employer: _____ Email:_____

Work Address:_____
(No. & street) (city or town) (state) (zip code)

In case of emergency, who should we contact?

_____Relationship_____Phone_(_____)_____

Medical History

Diagnosis (or area we will be treating) _____

Referring Doctor: _____ Primary Care Doctor_____

Are you a Harvard Vanguard Patient? Yes _____ No _____

Have you been treated by another Physical Therapy office in the past year? _____ If yes, When_____

Insurance Section: We will need to take a copy of your insurance card for verification and billing address info.

Primary Insurance Company: _____ID#:_____

Subscriber:_____ Subscriber D.O.B._____ Relationship to subscriber:_____

Secondary Insurance Company: Please list any secondary insurance here. This would include Medicare supplement plans, and your private insurance if a worker's compensation or auto carrier is primary.

Secondary Insurance Company:_____ ID#_____

Subscriber:_____ Subscriber D.O.B._____ Relationship to subscriber:_____

If **Medicare**, are you receiving or have you recently received **ANY** home services (including a nurse, home health aide)
Yes____ No_____

Check if worker comp or auto accident: W/C claim?_____ Auto accident?_____ Date of Injury:_____

IMPORTANT: **Copays, Co-Insurance, and Deductible amounts vary with each insurance plan. It is your responsibility to know the benefits and pre-authorization requirements of your health plan. We may be able to answer general questions regarding insurance plans that we are providers for, but each patient's' individual plan benefits will vary. Should my insurance company deny payment for my visit, I will be responsible for the charge.**

Signature: _____ Date: _____

(Continue on Backside)

Louis B. Coiro, P.T. dba
Tewksbury Physical Therapy, 885 Main Street #4, Tewksbury MA 01876
Drum Hill Physical and Sport Therapy, 10 Jean Avenue Unit 10, Chelmsford MA 01824

Patient Authorization for Treatment
For Physical Therapy (P.T.) and Occupational Therapy (O.T)

P.T./O.T. therapy is patient care services provided in response to a wide range of medical care needs of our patient of all ages regardless of gender, color, race, creed, national origin or disability.

The purpose of P.T./O.T. therapy is to treat disease, injury and disability by elevation, examination, testing and use of rehabilitation procedures, manipulations, massage, exercises, and physical agents including, but not limited to mechanical devices, heat, cold, light, water, electricity and sound in the aid of establishing a physical therapy functional diagnosis and treatment program; to obtain the information needed in evaluation of patients to prevent or minimize residual physical disability. P.T./O.T. can aid the patient in achieving their maximum potential within their capabilities, and accelerate convalescence and reduce the length of functional recovery. P.T./O.T. practice includes, but is not limited to, patient education, electrical stimulation, phonophoresis, iontophoresis, and application of topical medications, splinting and biofeed services.

You are not expected to experience any increase in your current pain level or discomfort. You should attempt to stop each procedure before you experience any increase in your current level of pain and discomfort and discuss this with your therapist.

You are expected to cooperate fully with the evaluation and stop any test or treatment before any increase in your current level of pain and discomfort. Because of the nature of services provided you may be ask to partially disrobe, in which case a hospital gown will be provided. If this is necessary, your privacy and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse, stop the procedure and/or request another therapist.

There are certain inherent risks with physical therapy and occupational therapy treatment because you will be asked to exert effort and perform activities with increasing degrees or difficulty which could cause an increase in your current level of pain and discomfort, inability to function or an aggravation of your current injury or problem. There is also a possibility that you could experience a new injury, but this risk is small and you can control any procedure which you feel may be harmful by stopping it if you feel any increase in your systems or sense new symptoms developing. Your physical and/or occupational therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure and/or comply with a treatment that you do not wish to perform and/or have performed on you.

Based on the above information, I agree to cooperate fully and to participate in all P.T./O.T. procedures. I give my consent to be evaluated and treated in physical therapy and/or occupational therapy. I acknowledge that I have read and received a copy of the Authorization for treatment letter. I authorize release of medical information to appropriate third parties.

Date: _____ Patient Signature: _____

Date: _____ Witness: _____ Title: _____

Patients Name: _____ Date of Birth _____

Male _____ Female _____ Height _____ FT _____ In Weight _____

1. **Cause of current episode:**
   Traumatic _____ Post-Surgical_____ Repetitive_____ Unspecified_____
   Work Related_____ Motor Vehicle_____

2. **Briefly describe your symptoms**:
   _____

3. **Symptoms began on**:
   _____

4. **How did your symptoms start?**
   _____

5. **Average pain intensity:**

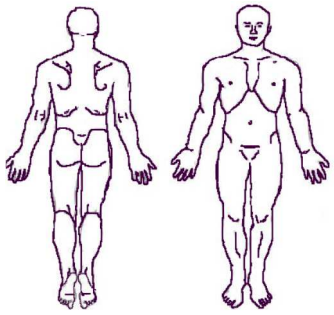
Last 24 Hours	no pain	0	1	2	3	4	5	6	7	8	9	10 worst pain
Past week	no pain	0	1	2	3	4	5	6	7	8	9	10 worst pain

6. **How often do you experience your symptoms? % of the time**
   1 Constantly (76-100%) 2 Frequently (51-75%)
   3 Occasionally (26-50%) 4 Intermittently (0-25%)

7. **How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)**
   1 Not at all2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

8. **In general, would you say your overall health right now is...**
   1 Excellent 2 Very Good 3 Good 4 Fair 5 Poor

Indicate where you have pain



9. **Have you received treatments for this condition before?**
   □ Yes □ No

10. **Please indicate the number of surgeries you have had for the area you are being treated for.**
    □ None □ 1 2 3 □ 4+

11. **How many days ago did the condition begin?**
    □ 0-7 days □ 8-14 □ 15-21 □ 22-90 □ 91days to 6 mos.□ Over 6 mos. Ago

12. **Are you taking any medication?**
    □ Yes □ No If yes, please list them_____
    _____

13. **How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition?**
    □ At least 3 times a week □ Once or twice per week □ Seldom or never

Please Flip Over To Finish Other Side

14. This is a statement other patients have made.

"I should not do physical activities which (might) make my pain worse."

□ Completely Disagree □ Unsure □ Somewhat Agree □ Somewhat Disagree □ Completely Agree

15. Other health problems may affect your treatment. Please check (□) any of the following that apply to you:

□ Arthritis (rheumatoid / osteoarthritis)
□ Asthma
□ Angina
□ Congestive heart failure (or heart disease)
□ Heart attack (Myocardial infarction)
□ Neurological Disease (such as Multiple Sclerosis or Parkinson's
□ Peripheral Vascular Disease
□ Diabetes Types I and II
□ Visual impairment (such as cataracts, glaucoma, macular degeneration)
□ Hearing impairment (very hard of hearing, even with hearing aids)
□ Kidney, bladder, prostate, or urination problems
□ Incontinence
□ Depression
□ Hepatitis / AIDS
□ Prosthesis / Implants
□ Cancer
□ Osteoporosis
□ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema
□ High blood pressure
Stroke or TIA
□Headaches
□ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
□ Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
□ Previous accidents
□ Allergies
□ Anxiety or Panic Disorders
□Other disorders
□ Prior surgery
□ Sleep dysfunction

Patient Signature _____ Date: _____