(OFFICE USE ONLY)

THERAPIST_____
REFERRING DOCTOR_____
INJURED AREA_____
ICD-10

body in balance physical therapy

2828 W 44th Ave., Denver, CO 80211
303-477-5303
www.physicaltherapydenver.com

PLEASE CALL 24 HOURS IN ADVANCE IF YOU NEED TO RESCHEDULE YOUR APPOINTMENT

PATIENT NAME_____SSN_____

ADDRESS_____CITY_____ZIP_____

PRIMARY PHONE_____H W C SECONDARY PHONE_____H W C

DOB_____AGE_____ MARITAL STATUS_____OCCUPATION_____

E-MAIL ADDRESS_____

EMERGENCY CONTACT_____RELATION_____PHONE_____

How did you hear about Body in Balance PT?_____

PLEASE PRESENT YOUR INSURANCE CARD AND I.D. TO THE OFFICE STAFF FOR PHOTOCOPYING

Is your injury: Work Related Auto Related Other Date of Injury or Surgery_____

Adjuster_____**Claim #**_____**MedPay Amount**_____

Medicare: Yes_____ **No**_____ **Supplement:**_____

Primary Insurance_____ **Insurance Phone**_____

ID#_____ **Group Name or #**_____

Responsible Party: Self Spouse Guardian Other Insured name & DOB_____

Secondary Insurance_____

Consent to Treat: I authorize Body In Balance Physical Therapy to render services as deemed necessary for the care of the above named Patient.
Medical Release of Information: I authorize Body In Balance Physical Therapy to release any medical information necessary to process this claim.
Assignment of Benefits: I hereby assign payment directly to Body In Balance Physical Therapy, the basic benefits as well as major medical benefits herein specified and otherwise payable to me, for the charges for this treatment period. I understand I am financially responsible for any charges not covered by my insurance. I understand that I will be held responsible for any costs incurred regarding collection of payment services rendered.
HIPPA Notice of Privacy Practices: I have read and understand my rights outlined in the HIPPA notice of privacy Practices as patient at Body in Balance Physical Therapy.

CANCELLATION POLICY: If you are unable to attend your scheduled appointment, we would appreciate at least 24-hour notice. No showing or canceling your appointment with less than 24-hour notice may result in a $60 charge.

The cancellation charge is not covered by your insurance policy and will be your responsibility.

FOR YOUR CONVENIENCE, WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD

Patient Signature_____ Date_____ Staff Init_____

A FINANCE CHARGE OF 10% WILL BE ASSESSED MONTHLY FOR ANY UNPAID BALANCE

MEDICAL SCREENING FORM

Name:_____ Age:_____ Occupation:_____

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

In the past 3 months have you had or do you experience:

Changes in your health……Yes…No
Changes in Appetite……Yes…No
Changes in bowel/bladder function……Yes…No
Dizziness……Yes…No
Difficulty Swallowing……Yes…No
Fever/Chills/Sweats……Yes…No
Infections ……Yes…No
Nausea/Vomiting……Yes…No
Numbness/Tingling……Yes…No
Shortness of Breath……Yes…No
Unexplained Weight Change……Yes…No

What prescription medications are you taking?

_____

__ _____

What over the counter medications are you taking?

_____

_____

Tobacco Use: Yes…No

If Yes: Packs per day:____ How many years:____

Alcohol consumption: Yes…No

If Yes: How many drinks per week: _____

Caffeine consumption: Yes…No

If Yes: Number of drinks per day:_____

Do you have a problem with:

☐ Hearing ☐ Vision ☐ Speech ☐ Communication

Present/Past Medical Conditions (circle):

AIDS……Yes…No
Allergies/Asthma……Yes…No
Angina/Chest Pain……Yes…No
Anxiety or Panic Disorders……Yes…No
Asthma……Yes…No
Back Pain
(neck pain, low back pain,
degenerative disk, stenosis) ……Yes…No
Cancer……Yes…No
Depression……Yes…No
Diabetes Type I or II……Yes…No
Diabetes……Yes…No
Fatigue……Yes…No
Gastrointestinal Disorder
(ulcer, hernia, reflux, bowel,
liver, gall bladder) ……Yes…No
Headaches……Yes…No
Heart Attack…… Yes…No
Heart Disease/CHF……Yes…No
Hepatitis……Yes…No
High Blood Pressure……Yes…No
Incontinence……Yes…No
Kidney Disease……Yes…No
Multiple Sclerosis……Yes…No
Osteoarthritis……Yes…No
Osteoporosis……Yes…No
Parkinson's…… Yes…No
Peripheral Vascular Disorder ……Yes…No
Pregnancy……Yes…No
Prosthesis/Implants ……Yes…No
Respiratory Disorders
(ARDS, COPD, Emphysema)……Yes…No
Rheumatoid Arthritis……Yes…No
Scoliosis……Yes…No
Seizures……Yes…No
Sleep Dysfunction……Yes…No
Stroke (or TIA)…… Yes…No
Thyroid Problems……Yes…No

Other:_____

Has anyone in your immediate family been diagnosed/treated for any of the conditions listed above? Yes…No

If yes please specify:_____

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Chief complaint:_____

Secondary or related complaint:_____

Date of onset:_____ Was the onset ☐ Gradual ☐ Sudden

Since onset, has it gotten ☐ Worse ☐ Better ☐ Same

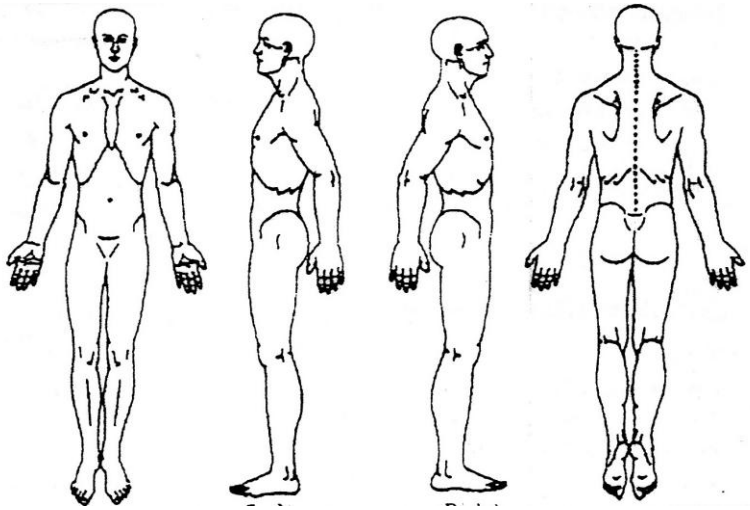
Describe what caused the pain:_____

What aggravates your pain? _____

What relieves your pain? _____

PAIN CHART
Please Mark Areas of Pain using these Codes!

+++	Burning
###	Dull/Ache
***	Numbness/Tingling
═══	Throbbing
000	Stabbing/Sharp



(FRONT) (LEFT) (RIGHT) (BACK)

SEVERITY OF PAIN

On a scale of 0 (being no pain)-10 (being the worst imaginable pain) please rate the following:

Chief Complaint:_____

At its BEST (0-10)_____ At its WORST (0-10)_____ AVERAGE (1-10)_____

Secondary Complaint (if any):_____

At its BEST (0-10)_____ At its WORST (0-10)_____ AVERAGE (1-10)_____

Current recreational/fitness activities:

_____

_____

_____

Goals for physical therapy:

_____

_____

_____

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