





**Insurance Information**

Name of Primary Insurance: \_\_\_\_\_

Name of Secondary Insurance: \_\_\_\_\_

Is this Injury related to a Workers Compensation Injury?:  Yes  No Motor Vehicle Accident?  Yes  No

Do you have an attorney for this injury?  Yes  No Attorney's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Financial Policy**

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. I understand that I am responsible for all supplies, such as braces or exercise equipment, which I am provided during treatment if they are not covered by my insurance plan. I understand that I will pay for supplies upon receipt.

I hereby give authorization for payment of insurance benefits to be made directly to MVPT for services rendered. In the event that my insurance company forwards payment directly to me, instead of MVPT, I will immediately deliver said payment to MVPT.

I understand & agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for MVPT to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a \$35 processing fee), and in addition attorney fees, court costs and other expenses of litigation.

I agree to release of medical or other information necessary to process my claim

Signature of Person Responsible for Charges: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Legal Guardian must sign if patient is under age of 18 years)

Relationship to Patient if patient is under 18 years of age:  Mother  Father  Legal Guardian

**Release of Information**

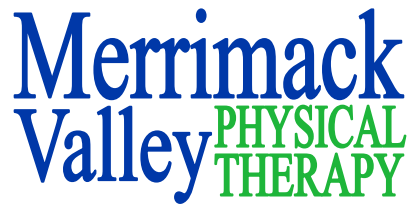
This form is an important legal document. It indicates the people who you are granting the privilege to access your medical information that is obtained by MVPT. The information includes, but is not limited to; diagnosis, treatment, attendance, billing, and any results of tests that MVPT has received from your other health care providers Please complete the following information and then please print your name legibly and sign in the spaces provided at the bottom.

I grant the following person access to the medical record established and maintained by MVPT.

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Legal Guardian must sign if patient is under age of 18 years)

Relationship to Patient if patient is under 18 years of age:  Mother  Father  Legal Guardian



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## Patient Commitment & Missed Appointment Policy

Thank you for choosing Merrimack Valley Physical Therapy; our staff will make every effort to ensure your experience here is both positive and productive so that you are able to achieve your functional goals. In order to give you the best possible outcome it is essential that you attend all your therapy appointments, as missing scheduled appointments greatly hinders progress toward your goals and may result in delaying your recovery.

In order to provide optimum outcomes and individualized care, we schedule our patients for one-on-one treatment times. We therefore respectfully require a 24 hour' notice for any appointment cancellation, which allows us the best opportunity to fill your appointment time with another patient who requires treatment.

**A 24 hours' notice is required for an appointment to be rescheduled.**

In an instance of a cancellation without 24 hours' notice or a no-show to a scheduled appointment, we reserve the right to charge a \$35 fee. Exceptions may be made in the case of an emergency, illness, or inclement weather. Please note that this charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

While there may be situations in which you must (with proper notice) cancel your appointment:

- **DO NOT CANCEL** if you are feeling worse or believe the treatment is not working. Please understand that your pain will probably fluctuate as your course of treatment progresses. Keep your appointment and discuss any changes in your symptoms with your therapist.
- **DO NOT CANCEL** if you are feeling better; keep your appointment in order to progress your plan of care and prepare for discharge.

Thank you for your cooperation with this policy.

Signing below indicates that you understand and agree to the terms of this policy.

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

(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under age of 18):  Mother  Father  Legal Guardian

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## Medical History

*Check all that Apply*

- |   |  |  |  |
|---|--|--|--|
| <input type="radio"/> Allergies               | <input type="radio"/> Chemical Dependency  | <input type="radio"/> Fractures            | <input type="radio"/> Osteoporosis         |
| <input type="radio"/> Anemia                  | <input type="radio"/> Circulation Problems | <input type="radio"/> Gallbladder Problems | <input type="radio"/> Parkinson's Disease  |
| <input type="radio"/> Anxiety                 | <input type="radio"/> Currently Pregnant   | <input type="radio"/> Hepatitis            | <input type="radio"/> Rheumatoid Arthritis |
| <input type="radio"/> Arthritis               | <input type="radio"/> Depression           | <input type="radio"/> High Blood Pressure  | <input type="radio"/> Seizures             |
| <input type="radio"/> Asthma                  | <input type="radio"/> Diabetes             | <input type="radio"/> Incontinence         | <input type="radio"/> Speech Problems      |
| <input type="radio"/> Cancer (any history of) | <input type="radio"/> Dizzy Spells         | <input type="radio"/> Kidney Problems      | <input type="radio"/> Strokes              |
| <input type="radio"/> Cardiac Condition       | <input type="radio"/> Emphysema/Bronchitis | <input type="radio"/> Metal Implants       | <input type="radio"/> Thyroid Disease      |
| <input type="radio"/> Cardiac Pacemaker       | <input type="radio"/> Fibromyalgia         | <input type="radio"/> Multiple Sclerosis   | <input type="radio"/> Vision Problems      |

Describe any other conditions or precautions: \_\_\_\_\_

## History of Falls

Injured as a result of a fall in the past year?  Yes  No      Date of Fall: \_\_\_\_\_

Two or more falls in the past year?       Yes  No      Date of Falls: \_\_\_\_\_

## Surgical History

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date of Surgery: \_\_\_\_/\_\_\_\_/\_\_\_\_

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Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date of Surgery: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Current Medications: mark if list is attached

(Route: oral, topical, inhaler, injection)

Drug: \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Route \_\_\_\_\_ Reason \_\_\_\_\_

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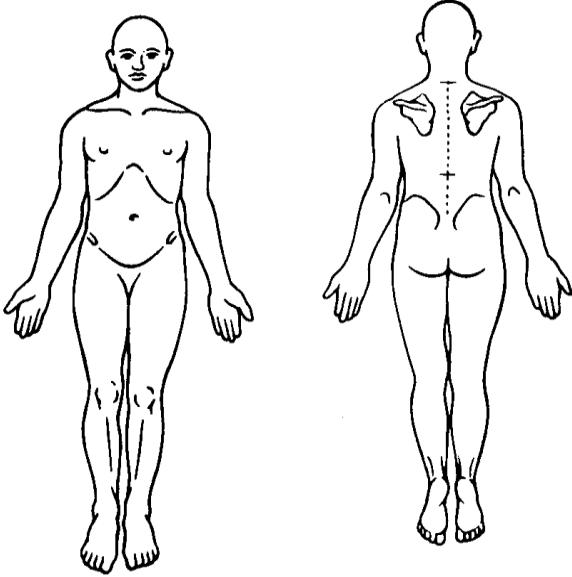
Drug: \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Route \_\_\_\_\_ Reason \_\_\_\_\_

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Present Condition

Please localize your **pain** or **abnormal** symptoms /sensations by marking on the body diagram below. (Mark picture where you have pain)



### **Pain at Rest:**

No Pain 0 1 2 3 4 5 6 7 8 9 10 unbearable pain

### **Pain with Movement**

No Pain 0 1 2 3 4 5 6 7 8 9 10 unbearable pain

**When did you first notice symptoms?** \_\_\_\_\_

**Was the onset of this episode gradual or sudden?**

gradual       sudden

Which of the following **best describes** how your injury occurred? (If your condition is post-surgical please indicate as per original injury)

- |   |  |
|---|--|
| <input type="radio"/> lifting                     | <input type="radio"/> a car accident       |
| <input type="radio"/> a fall                      | <input type="radio"/> an incident at work  |
| <input type="radio"/> overuse (cumulative trauma) | <input type="radio"/> trauma               |
| <input type="radio"/> degenerative process        | <input type="radio"/> medical condition    |
| <input type="radio"/> during recreation/sports    | <input type="radio"/> a dental appointment |
| <input type="radio"/> running                     | <input type="radio"/> unknown              |
| <input type="radio"/> other _____                 |  |

**Since the onset of your condition, are your symptoms getting:**

better       worse       not changing

**Have you experienced similar symptoms in the past?**

yes    no

**More than one episode?**  yes  no

**Nature of pain/symptoms** (check all that apply):

- |                                   |                                 |                                  |
|-----------------------------------|---------------------------------|----------------------------------|
| <input type="radio"/> sharp       | <input type="radio"/> aching    | <input type="radio"/> constant   |
| <input type="radio"/> dull        | <input type="radio"/> throbbing | <input type="radio"/> occasional |
| <input type="radio"/> burning     | <input type="radio"/> shooting  | <input type="radio"/> periodic   |
| <input type="radio"/> other _____ |                                 |                                  |

**Your symptoms are worse in the:**

- |  |                                 |                                    |
|--|---------------------------------|------------------------------------|
| <input type="radio"/> morning                  | <input type="radio"/> afternoon | <input type="radio"/> night        |
| <input type="radio"/> increased during the day |                                 | <input type="radio"/> same all day |

**Does the pain wake you at night?**

yes       no

**What aggravates your symptom's?** (check all that apply)

- |  |   |
|--|---|
| <input type="radio"/> sitting                      | <input type="radio"/> standing              |
| <input type="radio"/> going to/rising from sitting | <input type="radio"/> squatting             |
| <input type="radio"/> lying down                   | <input type="radio"/> sleeping              |
| <input type="radio"/> walking                      | <input type="radio"/> up/down stairs        |
| <input type="radio"/> reaching overhead            | <input type="radio"/> coughing/sneezing     |
| <input type="radio"/> reaching in front of body    | <input type="radio"/> taking a deep breath  |
| <input type="radio"/> reaching behind back         | <input type="radio"/> looking up overhead   |
| <input type="radio"/> reaching across body         | <input type="radio"/> sustained bending     |
| <input type="radio"/> household activities         | <input type="radio"/> recreations or sports |
| including _____                                    | including _____                             |
| <input type="radio"/> repetitive activities        | <input type="radio"/> stress                |
| <input type="radio"/> other _____                  |   |

**What eases your symptoms?** (check all that apply)

- |                                   |                                  |                                  |
|-----------------------------------|----------------------------------|----------------------------------|
| <input type="radio"/> cold        | <input type="radio"/> rest       | <input type="radio"/> sitting    |
| <input type="radio"/> heat        | <input type="radio"/> massage    | <input type="radio"/> standing   |
| <input type="radio"/> rest        | <input type="radio"/> stretching | <input type="radio"/> lying down |
| <input type="radio"/> medication  | <input type="radio"/> exercise   | <input type="radio"/> nothing    |
| <input type="radio"/> other _____ |                                  |                                  |

**How would you rate your general health?**

Excellent    Good    Average    Fair    Poor

**Living Situation**

- |  |   |
|--|---|
| <input type="radio"/> live alone                     | <input type="radio"/> live with caregiver |
| <input type="radio"/> live with family members/other | <input type="radio"/> assisted living     |

**Setting**

- |   |                                 |                                     |
|---|---------------------------------|-------------------------------------|
| <input type="radio"/> stairs (railing)    | <input type="radio"/> no stairs | <input type="radio"/> elevator      |
| <input type="radio"/> stairs (no railing) | <input type="radio"/> ramp      | <input type="radio"/> uneven ground |