Admission Record

Form Completion Instructions:

Please answer all fields (Please enter N/A if not applicable). All information will remain strictly confidential. Questions, please ask our office associate.

<table>
<tr><td colspan="3">Client Name:</td><td>Client Date of Birth</td><td>Social Security Number
__ __ __ - __ __ - __ __ __ __</td></tr>
<tr><td colspan="3">Mailing Address (No. & Street, Apt., etc.)</td><td colspan="2">E-Mail Address (Required)</td></tr>
<tr><td>City</td><td>State</td><td>Zip Code</td><td colspan="2">Cell Phone Number
(   )</td></tr>
<tr><td>Home Phone Number
(   )</td><td colspan="2">Work Phone Number
(   )</td><td colspan="2">Preferred Phone Contact
☐ Cell ☐ Home ☐ Work</td></tr>
<tr><td colspan="3">Primary Insurance Carrier Name</td><td colspan="2">Secondary Insurance Carrier Name</td></tr>
<tr><td colspan="3">Insured’s relationship to you
☐ Self ☐ Parent ☐ Spouse ☐ Other</td><td colspan="2">Insured’s Name (Who carries insurance contract)</td></tr>
<tr><td colspan="3">Insured’s Employer Name:</td><td colspan="2">Insured’s Employer Address:</td></tr>
<tr><td>City</td><td>State</td><td>Zip</td><td colspan="2">Employer Phone Number:</td></tr>
<tr><td colspan="3">Insured’s Date Of Birth:</td><td colspan="2">Emergency Contact and Phone</td></tr>
<tr><td colspan="3">Is this injury from a Motor Vehicle Accident?
☐ Yes ☐ No</td><td colspan="2">Is this injury from a Workmans Comp. claim?
☐ Yes ☐ No</td></tr>
<tr><td colspan="3">If yes, what is the name of the claims adjuster?</td><td colspan="2">If yes, what is the phone number of the claims adjuster?</td></tr>
<tr><td colspan="3">Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed</td><td colspan="2">Your occupation:</td></tr>
<tr><td colspan="3">Spouses Name:</td><td>Spouses Date of Birth</td><td>Social Security Number</td></tr>
<tr><td colspan="3">PRIMARY CARE Physician Name</td><td>Phone Number</td><td>Date of Next Office Visit</td></tr>
<tr><td colspan="3">REFERRING Physician Name (If any)</td><td>Phone Number</td><td>Date of Next Office Visit</td></tr>
<tr><td colspan="5">Select all that apply: “I’m coming to Borja Physical Therapy now because of…”
☐ Friend/Family Member ☐ Online Search ☐ Valpak ☐ Radio ☐ Report
☐ My Doctor/Health Provider ☐ Facebook ☐ Google ☐ Newsletter ☐ Workshop
☐ My Insurance Website ☐ Newspaper ☐ Local Network ☐ Saw Sign ☐ Other:
____________________</td></tr>
</table>

Client Authorization And Responsibility

I hereby consent to treatment at Borja Physical Therapy PLLC. By consenting to treatment I authorize, on behalf of any covered family member or myself, direct billing of my insurance company and direct payment to Borja Physical Therapy PLLC. By consenting to treatment, I also consent to the release of necessary medical

information needed for the processing of the insurance claims, including release to any entity for the continuation of my medical care. I understand that a photocopy of the release is as valid as the original. In the event that my insurance company does not pay or partially pays on behalf of any covered family member or myself, I understand that it is my financial responsibility to remit payment in full to Borja Physical Therapy PLLC upon completion of the treatment sessions or within 30 days thereafter. I further understand that if the matter is referred to an attorney for collection, I will be responsible for the attorney's fees and court costs.

Signature of Client/Guardian/Parent	**Date**

Missed Appointments Policy

Borja Physical Therapy must receive 24-hour advance notice for cancelled appointments. Clients who do not provide 24-hour notice for their cancellation will be responsible for a $15.00 cancellation charge. Clients who do provide 24-hour notice for their cancellation will not be charged a cancellation fee. Clients who fail to cancel and fail to attend a scheduled appointment will be responsible for a $25.00 charge. These charges cannot be billed to insurance and must be paid on or before the next scheduled appointment. After two cancellations, we reserve the right to require same day appointment reservations or discharge from therapy services altogether with non-compliance documentation.

Signature of Client/Guardian/Parent	**Date**

Notice Of Privacy Practices

I hereby authorize that I am aware of my rights as it pertains to HIPAA and my Protected Health Information (PHI). Borja Physical Therapy has offered me a copy of their Notice of Privacy Practice for my own records. You may see our privacy practices at: borjapt.com/privacy-notice/ or request a copy from our Customer Service associate.

Signature of Client/Guardian/Parent	**Date**

No-Show / Cancellation Policy

Please Read Carefully

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other clients scheduling needs and keeps the clinic operating at its most efficient level. We strive to promote a higher quality of care at Borja PT, and as such, missed,or late appointments are a significant disruption to the clinic, your physical therapist and other patients.

1. Please provide our office with 24-hour notice to change or cancel an appointment. Clients who do not attend a scheduled appointment may be responsible for a $15.00 cancellation charge. Clients who do not provide 24-hour notice to change a scheduled appointment may be responsible for a $25.00 no call/no show charge. These charges cannot be billed to insurance and must be paid on or before the next scheduled appointment.
2. We reserve your appointment time just for you. We do not double-book our clients so that we may provide optimum treatment outcomes. The 24-hour notice allows us to place another client in your canceled appointment period.
3. Your treatment plan has been established by you and your practitioners to help you to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.
4. Certain accident claims adjusters and application for disability will require regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or canceled on a regular basis it could affect the status of your claim.
5. After missing two appointments without notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

Thank you for providing our office and our patients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

Signature of Client/Guardian/Parent ____________________________ Date ______________________

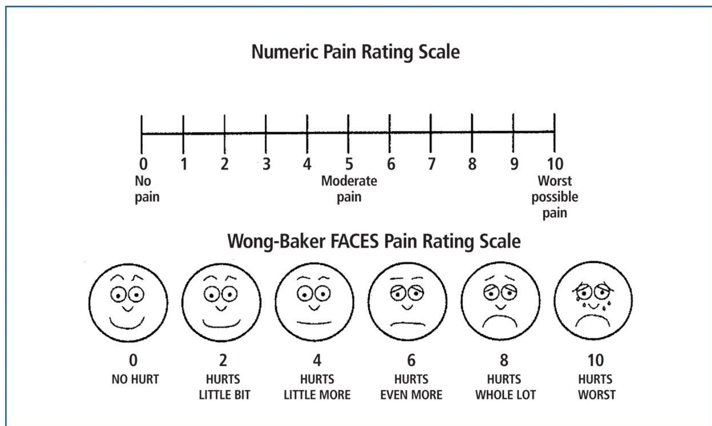
Medical History Information

Your Name ________________________ Your Age: ______

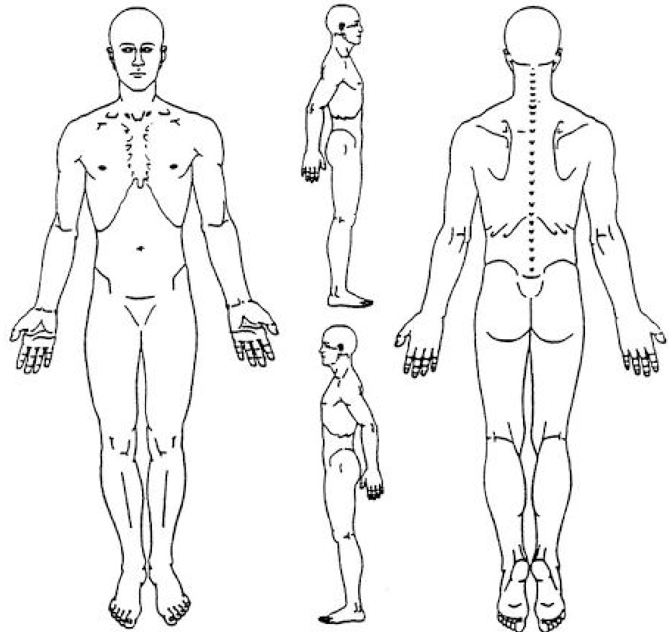
Use this chart to help you describe your particular level of pain to your health care provider.

☐ I have no pain ☐ Pinching ☐ Throbbing
☐ Stabbing ☐ Burning ☐ Persistent
☐ Dull ☐ Steady ☐ Comes & goes
☐ Aching ☐ Localized ☐ Pinching
☐ Other (please describe) ____

Use the chart below to assess your pain level:



Please shade or circle the areas where you are experiencing pain.



My pain at it's worst is:

0 1 2 3 4 5 6 7 8 9 10
(Circle one)

My pain on average is:

0 1 2 3 4 5 6 7 8 9 10
(Circle one)

1. What was the specific cause of injury, or the series of events leading up to your visit today?

Description: ____

____

2. When were you injured? ________________________. Was your pain ☐ **Sudden** or ☐ **Gradual**?

3. Was your injury: ☐ Sudden or ☐ Gradual?

4. Medical History: Select all that apply to you. Have you been diagnosed with the following:

Arthritis/Osteoarthritis?	☐ Yes ☐ No	Diabetes Type 1?	☐ Yes ☐ No
Rheumatoid Arthritis?	☐ Yes ☐ No	Diabetes Type 2?	☐ Yes ☐ No
Osteoporosis?	☐ Yes ☐ No	Obese?	☐ Yes ☐ No
High blood pressure?	☐ Yes ☐ No	Seizures?	☐ Yes ☐ No
Heart/circulation disorders?	☐ Yes ☐ No	Dizzy Spells?	☐ Yes ☐ No
Immune deficiency disease?	☐ Yes ☐ No	History of Cancer?	☐ Yes ☐ No
History of falling?	☐ Yes ☐ No	Currently pregnant?	☐ Yes ☐ No
Hard of hearing?	☐ Yes ☐ No	Vision Difficulty?	☐ Yes ☐ No

Explain / Other not listed:

____

____

5. Imaging: Check all imaging performed for your condition:

☐ X-ray ☐ MRI ☐ CT Scan ☐ Other: ___________________________ When?

____

What were the results? ____

6. Surgery: Please list any and all surgeries you have had at or near your injury site and include year performed.

____

7. **List medications you are taking now:** If you brought a list, we can make a copy. If no list today, please list below. We cannot see you without a list of medications today. Please include name, dosage and frequency.

____

____

8. List any allergies you have: ____

Name of person completing this form (print)	Signature of Client or Responsible Adult and Date

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Do NOT complete this section. This section to be completed by your physical therapy clinician.

Clinical Notes

ROM:

Flexion:	_____°	Flexion:	_____°
Extension:	_____°	Extension:	_____°
Abduction:	_____°	Abduction:	_____°
Internal Rotation:	_____°	Internal Rotation:	_____°
External Rotation:	_____°	External Rotation:	_____°
Side Bend R:	_____°	Side Bend R:	_____°
Side Bend L:	_____°	Side Bend L:	_____°
Rotation R:	_____°	Rotation R:	_____°
Rotation L:	_____°	Rotation L:	_____°

MMT:

Flexion:	_____ /5	Flexion:	_____ /5
Extension:	_____ /5	Extension:	_____ /5
Abduction:	_____ /5	Abduction:	_____ /5
Internal Rotation:	_____ /5	Internal Rotation:	_____ /5
External Rotation:	_____ /5	External Rotation:	_____ /5
Side Bend R:	_____ /5	Side Bend R:	_____ /5
Side Bend L:	_____ /5	Side Bend L:	_____ /5
Rotation R:	_____ /5	Rotation R:	_____ /5
Rotation L:	_____ /5	Rotation L:	_____ /5

Pain increases with: ☐ Passive ☐ Active ☐ Flexion ☐ Extension ☐ Rot. R ☐ Rot. L ☐ Other: _________________________

Pain decreases with: ☐ Passive ☐ Active ☐ Flexion ☐ Extension ☐ Rot. R ☐ Rot. L ☐ Other: _________________________

Special Testing

(+)(-) (+)(-) (+)(-) (+)(-)

☐☐ SLR	☐☐ Hip IR test	☐☐ Thessaly's Test	☐☐ Hawkins-Kenney
☐☐ Fabers	☐☐ Thomas test	☐☐ ACL/PCL/MCL/LCL	☐☐ Impingement
☐☐ Piriformis sign	☐☐ Patellar Tracking	☐☐ Lat Jt line	☐☐ Biceps load test
☐☐ Slump test	☐☐ Excessive Q angle	☐☐ Medial Jt line	☐☐ A/C compression
☐☐ Instability test	☐☐ IT band syndrome	☐☐ ________________	☐☐ __________________