201 Hamakua Dr. C102-C ~ Kailua, HI, 96734
Phone: 597-1005 ~ Fax: 808-597-1006

PHYSICAL THERAPY QUESTIONNAIRE

Name:_____ Age:_____ Date:_____

Date of Injury:_____ Occupation:_____

Please describe your current complaint:_____

_____

_____

Please describe how & when your problem began:_____

_____

_____

Onset of Symptoms (circle one): Gradual Immediate

Pain is (circle one): Constant Comes & Goes At Rest

How would you describe your pain?: _____

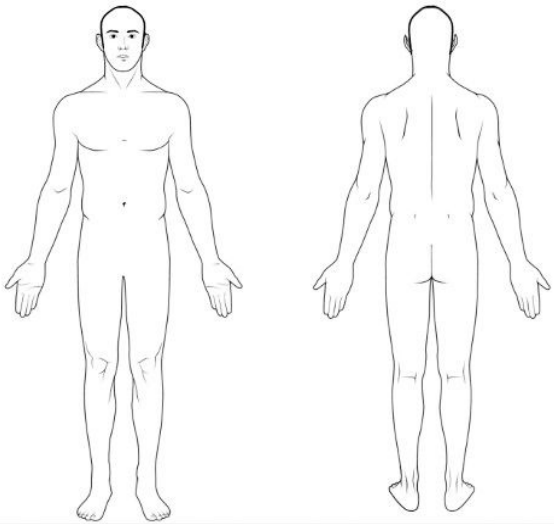
Indicate your pain at its: *0 = No Pain 10 = Unbearable Pain*

Worst: 0 1 2 3 4 5 6 7 8 9 10

Currently: 0 1 2 3 4 5 6 7 8 9 10

Best: 0 1 2 3 4 5 6 7 8 9 10

Circle where your pain is located:



Your symptoms are worse in (Circle) :

AM PM As the day progresses Same all day

What activities increase your pain? _____

What activities decrease your pain? _____

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Disturbed sleep due to pain?: Yes No Difficult sleeping positions:_____

Diagnostic Testing: X-Ray EMG MRI CT Scan Bone Scan Date Performed?: _____

Previous/Current Treatment (Circle all that apply): Land-Based Physical Therapy Aquatic Therapy Massage Chiropractic Injections Rest

Recreational activities prior to onset:_____
_____

Current activities able to participate in:_____
_____

What everyday activities are you unable to perform currently:_____
_____

History of Surgical Procedures (Add Dates):_____
_____

List all Current Medications:_____
_____

Patient Goals for Physical Therapy:_____

Do you have or have you recently had any of the following complaints?

___ Shortness of breath
___ Dizziness or lightheadedness
___ High Blood Pressure
___ Heart Trouble
___ Stroke (If yes, when?: _____)
___ Persistent pain at night
___ Unexplained weight loss (10-15lbs in 2 weeks)
___ Loss of appetite
___ Depression
___ Arthritis
___ Change or problems with bladder/bowel function (i.e. incontinence, UTI)
___ Frequent or severe headaches
___ Problems with balance or falling
___ Diabetes
___ Tuberculosis
___ HIV Positive
___ Currently Pregnant?
___ Epilepsy or seizures
___ Allergies: what type:_____
___ History of Cancer: what type: _____
___ Other: _____

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PATIENT INFORMATION

Date_____ Birthdate_____

Name: Last_____First_____Middle_____

Address_____

City_____State_____Zipcode_____

Home Phone_____Cell Phone_____

Email Address_____

Appointment Reminders: Text Message Phone Call Email
Home / Cell

***All appointment reminders are sent as an automated message. If you need to reschedule or cancel any appointments or have a question, please call us at 808-597-1005. Each scheduled reminder will be sent 24 hours prior to your appointment.**

Sex: M / F Minor Single Married Divorced Widow

Employer_____ Business Phone_____

Business Address_____Occupation_____

How did you hear about us?_____

In case of emergency, contact:_____ Ph._____ Relationship_____

PRIMARY INSURANCE:_____

SECONDARY INSURANCE:_____

ASSIGNMENT & RELEASE

I hereby authorize payment directly to Moon Physical Therapy, LLC all insurance benefits otherwise payable to me or services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents.
I authorize Moon Physical Therapy, LLC to release any information required to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____Date_____

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OFFICE POLICIES

HIPAA-NOTICE OF PRIVACY PRACTICES. By my signature below, I acknowledge that I have read and understand the HIPAA privacy practices set by this clinic and Secretary of Health and Human Services. I understand that I will be given a copy of the HIPAA notice upon my request. _____ Initial

The overwhelming majority of insurance plans do not cover all treatment in full. You are responsible at the time of service for your co-payments, all deductibles, any disputed amounts between you and your insurance company and anything that is not covered by your insurance. We cannot make exceptions, as it is illegal to do so. As we are not an insurance company, nor do we work for or represent any such company, we cannot guarantee any eligibility, extent of coverage or any payment by your insurance company. You are ultimately responsible for any outstanding balance. We want to remind you that it is your responsibility to make sure that we always have your most current insurance information on file. _____ Initial

CANCELLATION & NO-SHOW POLICY. Failing to call with less than a 24 hour notice or not showing up for an appointment hinders our ability to provide the best possible care for our patients. Therefore we have instituted a **No-Show / Late Cancellation Policy and we reserve the right to charge you at $50.00 fee**. This charge WILL NOT be covered by your insurance, but WILL HAVE TO BE PAID IN FULL BY YOU prior to receiving additional treatment.
We ask that you cancel 24 hours prior to your appointment if need be. This will allow us the opportunity to offer that appointment time to another patient.
Two late cancellations or no-shows will result in discontinuation of therapy. If this is the case your referring provider or case manager will be notified of the reason you were discharged. _____ Initial

POOL POLICY. I declare that I am fully aware and understand that in the event **I voluntarily or involuntarily urinate, defecate, or regurgitate in Moon Physical Therapy's pool or Hydroworx, I will pay to Moon Physical therapy $250.00 for cleaning and disinfecting**. I understand that as a result I will no longer be allowed to participate in Moon Physical Therapy's aquatic program. _____ Initial

The above information has been read and explained to me if needed. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____
Patient/Guardian/Responsible Party Signature Date