201 Hamakua Dr. C102-C ~ Kailua, HI, 96734
Phone: (808) 597-1005 Ext. 4 ~ Fax: (808) 913-5295

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?: _____

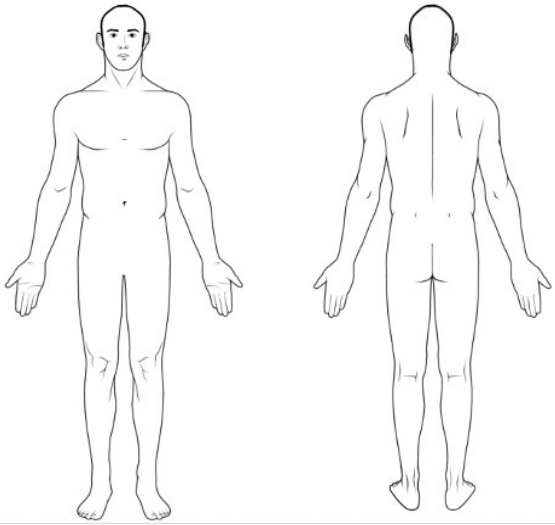
Indicate your pain at its: *0 = No Pain 10 = Unbearable Pain*

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 **first** 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_____

New Patient Agreement

Mahalo for choosing Moon Physical Therapy as your health provider - we truly appreciate your support and will do our absolute best to provide you with exceptional health care solutions for many years to come.

We Need Your Help

We are here for you and will do everything we can to help you achieve your goals. In order to do that, we need to work as a team and so it is important that you understand and agree to our terms and conditions outlined below:

1. **Your Feedback is Vital:** At the end of your session **TODAY you will be completing a short feedback form** where you get the chance to let us know how our Patient Care Coordinators & Clinicians managed your care. Your input is pivotal to our business success and growth so please fill out this form honestly and accurately. You will also be asked to complete a similar form at other times during your treatment journey – just so we know we are on track.

   _____ Initial

2. **Documentation**: We understand that it is essential for you to feel your team is focused on you and your healing during your session. At our clinic, it is normal practice to take notes during treatment sessions on our laptops. So this means that the therapists will periodically be looking down to document as they assess and progress you. This will only help your team so that you will be able to receive the best care possible.

   _____ Initial

3. **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

4. **Insurance Coverage:** 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

5. **Pool Policy:** We ask that **all aqua therapy patients bring a towel and arrive 10 minutes before their scheduled appointment** in order to change and rinse off prior to their session. **Rinsing off at our facility is required for all patients before entering the water to maintain proper PH levels.** 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 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

_____ _____ _____

Patient Signature Patient Name Date

Missed Visit Policy

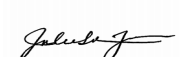
At Moon Physical Therapy, our goal is to help all patients reach a fully recovered state. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you achieve your goals. Patients who attend all of their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lower potential for recovery. We are happy to share a copy of this study with you but want to make sure you understand that it is extremely important you attend all of the appointments. This policy ensures that all patients have the opportunity to receive the care they need.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. As experts, we know that **you will not reach full recovery if you do not attend your appointments**. To help ensure you have the best chance at recovery, we will work with you to schedule out all of your appointments after your evaluation today and in order to have the best chance at recovery, you will need to attend each visit.
2. Please note: Our goal is to begin your treatment sessions on schedule. For all **LAND** appointments, we expect that you will arrive at least 5 minutes prior to your appointment time, dressed for your session, and ready to begin on time. This will allow our front office to handle their responsibilities and our specialists to provide the care you need and deserve.
3. If you're late for your appointment, you're missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else.
4. If you're running late, we need you to call us immediately so we can prepare for your late arrival and consult with your clinician. If you are more than 15 minutes late, your session may need to be rescheduled and if that occurs, you will incur a missed visit charge. Chronically late patients will be asked to change their appointment times.
5. While we understand that illness can strike at any time, we still expect that you will work to provide at least a day's notice if you cannot attend a scheduled appointment.
6. Providing care to all patients is extremely important to us and late notice of changes or cancellations will keep someone else from getting the care they need and deserve. **If you need to cancel or change a scheduled appointment, for any reason, we require 24 hours' notice during business hours, so we have enough time to help another patient who needs to get in for the care they need and deserve.**
7. When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
8. **We reserve the right to charge a missed visit fee of $150 if you do not provide at least a days' notice of your appointment change or cancellation.**
9. **To avoid our missed visit fee, we need you to call our office during business hours - at least 24 hours in advance for any illness, appointment changes or cancellations. (For reference, if you had an appointment at 11am today, we would have needed to hear from you by 11am yesterday to avoid issues with our policy.)**
10. Patients who have multiple same-day cancellations or no-shows, will be removed from the active schedule and will be placed on the day-to-day list to avoid future missed visit charges. We will also notify your physician of your non-compliance.
11. If you are under worker's comp, we are required to notify your claims adjuster if you cancel or no-show for an appointment.

We look forward to working with you to meet your physical therapy goals. To avoid any issues with our policy, we only need the required notice, so we have enough time to help all patients to get in for the care they need and deserve.

Julie Moon, Owner



This policy has been reviewed with me and by signing below I am indicating that I understand this policy

_____	_____	_____
Patient Signature	Patient Name	Date