Phone: (541) 535-2551
Fax: (541) 535-1417
Email: painhelp@turningpointpt.com
Web: www.turningpointpt.com
331 South Pacific Highway
(Hwy 99 North)
Talent, Oregon 97540

This cover sheet may be used as a FAX Cover.

FROM: ____________________________________

NUMBER OF PAGES: _______________________

DATE: _____________________________________

CONTACT PHONE: _________________________

NOTES: ____________________________________
____
____
____

Welcome to Turning Point Physical Therapy! Your therapy experience is very important to us and we will strive to deliver your services in a professional and enjoyable manner. Please read the following office policies thoroughly. ***Paperwork must be completely filled out before your scheduled appointment time or the provider will not be able to see you. Thank you.***

- **Appointment Policy:** If you must cancel or reschedule an appointment, Please notify the physical therapy office **at least 24 hours in advance**. ***One exception for unpredictable circumstances will be allowed.*** Missed appointments are costly to our practice and deprive other patients of the opportunity to receive care. **A $50.00 fee** will be assessed, prior to continued treatment, for failure to properly reschedule or cancel a therapy appointment. Your attention to this matter is most appreciated.
- **Late Arrivals to Appointment:** If you are going to be late for a scheduled appointment please contact our office. In the event you are 15 minutes or more, we may not be able to see you. This will be left up to the discretion of the physical therapist, however, if you are seen the appointment time will be reduced to allow for the time you were late.
- **Financial Policies:** *Insurance:* We will try to provide an explanation of your insurance benefits; however, it is ultimately **your** responsibility to verify coverage. **IT IS YOUR RESONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR OTHER BALANCE LEFT UNPAID BY YOUR INSURANCE COMPANY. As of July 1st 2010 you may be assessed a 1.5% finance charge (18% annual percentage rate) on balances 90 days old.**
  ***Medicare Patients:** *Medicare now requires that patients in physical therapy program must be seen by their prescribing physician every 60 days from the time you start therapy. It is your responsibility to schedule these appointments with your doctor.*
  ***Motor Vehicle Insurance:** As a courtesy, we will bill your MVA insurance company. Persons involved in a **LITIGATED SUIT** will **be expected to make payments** on any balance they may accumulate while being treated at this facility.
  *** Co-Pay Policies:** If your policy involves a co-payment, the amount of the co-pay **must** be made at the time of service.
  *** Fees:** Services and fees are available by contacting our billing department at (541)535-2551.
- **There is a $10.00 fee for copying of Medical Records for patient's private use.**
- **Medical Record Review with patient is provided for a cost of $25.00 per/hour.**
- **Child Care:** Please make arrangements for child care and pets. Children and pets are not allowed in the therapy department due to potential disruption of care and safety considerations.

I HAVE READ AND UNDERSTAND THIS POLICY STATEMENT AS SET FORTH AND AGREE TO FOLLOW THE PROCEDURES AS OUTLINED.

Signature: ______________________________ *Date:* ____________________

WELCOME TO OUR OFFICE

PATIENT INFORMATION Today's Date: ____/____/______

Patient Legal Name: ____

Last **First** **Middle**

Birthday: _____/_____/______ **SSN#:** ______/___/_______

Physical Address: ____

City: ____________________________________ **State:** _______ **Zip Code:** _________________

Mailing Address: ____

City: ____________________________________ **State:** _______ **Zip Code:** _________________

Home Phone: (______) _______- ___________ Cell: (_____) _______- ____________

Employment Status: Full time/ Part Time/ Unemployed/ Disabled

Employer: ____

Employers Address: ____

City: __________________________________ **State:** ________ **Zip Code:** __________________

Employers Phone Number: (_____) _______- ______________

Student Status: Full Time/ Part Time/ NA

Marital Status: Married / Single / Legally Separated / Divorced / Widowed

Name of Spouse: ____

Emergency Contact: _______________________________ **Phone# (____) ______- _________________**

Referring Doctor: _____________________________________

Primary Doctor: ______________________________________

Turning Point Physical Therapy

331 S. Pac. Hwy.

Talent, OR. 97540

Phone: 541-535-2551

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MEDICAL HISTORY

Name: ____ **Date:** _________________________________

1. **Do you have an advanced directive?** YES / NO
2. **Onset date? (date within last 6 month of the issue or symptoms worsening)** _____________________
3. **Primary diagnosis? (Worst complaint you are here for...)** ______________________________________
4. **Medications? (Please list any prescriptions, medications, over the counter drugs you are taking including skin patches, ect.** ____
5. **Physician? (Practitioner who sent you to physical therapy)** _____________________________________
6. **Occupation?** ____
7. **Age?** _______________ **D.O.B.** ____/____/______
8. **Gender?** M/F
9. **Mechanism of injury: (Please check one or explain how your injury occurred?)**

   Lifting ___ Car accident ___ a fall ___
   Trauma/accident ___ Degenerative process ___ Overuse trauma ___
   Running ___ Blow to the face___ Sports injury ___
   Throwing ___ Hit by a ball ___ Unknown ___
   Other ____
   ____

10. **What are your current symptoms? (Check all that apply and write-in if needed)**

    Pain ___ Mechanical pain ___ Pins and needles ___
    Fever/chills/sweats ___ Syncope ___ Night pains ___
    Malaise ___ Dyspnea ___ Bowel dysfunction ___
    Nausea/vomiting ___ Numbness ___ Sexual dysfunction ___
    Weakness ___ Dysuria ___ Dizziness ___
    Headaches ___ Urinary frequency changes ___
    Unexplained weight changes ___ other ____
    ____

11. **Other diagnosis? (Have you ever been diagnosed with any of the following.. check all that apply)**

    Cancer ___ Osteoarthritis ___ Depression___
    High blood pressure ___ Hepatitis ___ Stroke ___
    Tuberculosis ___ Emphysema ___ Anemia ___
    Kidney Disease ___ Chemical dependency ___ Diabetes ___
    Anorexia/bulimia ___ Thyroid problems ___ Epilepsy ___
    Raynauds disease ___ Multiple sclerosis ___ Allergies ___
    HIV/Aids ___ Rheumatoid arthritis ___ Bronchitis ___
    Heart problems ___ other (write-in) ____

12. **Age of condition?** ____
13. **Have you had Physical Therapy before?** Y/N
14. **Practitioners seen for this condition? (Check if applicable)**

    Dentist ___ Psychiatrist/Psychologist ___ Chiropractors ___
    Massage Therapists ___ Osteopath ___ Acupuncturists ___
    Other (write-in) ___________________________________

15. **Do you have any of the following (Contraindications to some physical therapy treatment. Check and or write-in)**
    Total hip replacement ___ Pacemaker ___ No sensation ____________ Other ______________________
16. **Prior Level of Function (How long have your symptoms lasted?)___________________________________**
17. **Previous treatment for this condition includes? (Check if applicable and/or write-in)**
    Laser therapy ___ Medication ___ Physical therapy ___
    Massage therapy ___ Chiropractic ___ Acupuncture ___
    Other____
18. **Write in your Pain level at best (0-10)? ________ Pain level at worst (0-10)? ________**
19. **Current functional problems posing a change due to pain or symptoms? (Check all that apply...)**
    Walking ___ Work ___ Personal Care ___ Sleeping ___
    Dressing ___ Stairs ___ Reaching ___ Sitting ___
    Carrying ___ Reading ___ Driving ___ Recreation/Sports ___
    Headaches ___ Lifting ___ Talking ___ Concentration ___
    Standing ___ Eating ___ Squatting ___ walking (uneven ground) ___
20. **Was the onset of this condition gradual or sudden? ____**
21. **Since the onset are your symptoms getting better, worse or no change? _____________________**
22. **How many times have you had similar symptoms in the past? (Check one or write-in) _________**
    None ________ One to five ________ More than fine _______
23. **Have you ever had a surgery? Y/N If yes, was the surgery related in any way to you current symptoms (Please explain)? ____**
24. **Nature of pain? (Check all that apply and/or write-in)**
    Sharp ___ Dull ___ Throbbing ___ Aching ___ Periodic ___ Occasional ___ Constant ___
    Other ____
25. **Has anyone in your immediate family ever been treated for the following? (Check all that apply and/or write-in)**
    Cancer ___ arthritis ___ Mental illness ___ High blood pressure ___ Hepatitis ___
    Stroke ___ Tuberculosis ___ Emphysema ___ Anemia ___ Kidney disease ___
    Chemical dependency ___ Diabetes ___ Epilepsy ___ Heart problems ___
    Other ____
26. **How many packs of cigarettes do you smoke a day? ______**
27. **How many caffeinated (coffee, soda pop) drinks do you drink per day? ________**
28. **How many alcoholic drinks do you consume per day ______ per week? ______**
29. **How many days per week do you smoke marijuana? _____**
30. **Do you have any issues with sensation (i.e. numbness, lack of hot/cold sensation, pins and needles, etc.) If so, where do you experience this? ____**
31. **Is there anything else missed on this questionnaire that you think needs to be mentioned?**
    ____
    ____

FINANCIAL RESPONSIBILITY DISCLAIMER

Name: ____ Date: __________________

Phone Number: (___) _____-__________ Referring Dr: ______________________________

We are happy to bill your insurance. However, **you are responsible** for contacting your insurance to clarify your individual coverage for physical therapy. Some insurance companies limit the number of physical therapy visits in a given year. If this is the case, please notify your therapist so that your program can be designed to fit into these limitations. Also, you must keep track of your visits so you don't exceed the parameters (number of visits allowed per calendar year or per year). If payment is denied for too many visits, **you are responsible for those charges.**

If you have any questions, please discuss them with the front office. It is our goal to provide you a program that is both successful for your physical needs and financial restrictions and responsibilities.

I acknowledge that it is my responsibility to verify insurance coverage with my insurance company. I understand that I am financially responsible for any charges incurred with my physical therapy in the event that my insurance company fails to cover any charges.

PATIENT SIGNATURE: __________________________________ *DATE:* __________________

INSURANCE INFORMATION

Is this appointment the result of an accident or injury? ______YES ______NO

Circle One: Motor Vehicle/Workers' Comp. /Personal Injury

Date of injury ___/___/_____ Policy #/ Claim # ______________________________

Insurance Company Name: ____

Claims Address: ____

City: __________________________ State: ______ Zip Code: _____________________

Adjuster/Agent Name: ____

Phone Number: (____) ______- ___________ Ext. ______________

Employer: ____

If your insurance has changed since you last visit please bring in your card so we may get a copy for your files.

Patient Signature: __________________________________ Date: _________________

HEALTH RISK ANALYSIS
LIFESTYLE QUESTIONNAIRE

DATE OF ANALYSIS
____
NAME
____
ADDRESS
____
CITY STATE ZIP
(_____)______________________ (_____)_________________
HOME PHONE WORK PHONE
_____/_____/_____ _____________________
DATE OF BIRTH SEX

==

How to complete the questionnaire.

The information you supply in the following *Health Risk Analysis* questionnaire will be used to develop a profile of your current risk status for coronary heart disease, cancer and other lifestyle related concerns. All of the information you provide is strictly confidential. Honest and accurate answers will provide a meaningful health risk analysis report. You should read and understand each question thoroughly and then place an "X" in front of each appropriate response.

Patient: ____

Section A
Non-Controllable Risk Factors

1.0 Family history of Coronary Heart Disease occurring before 60 years old.
Indicate the number of members of your direct family (related by birth) who have died or been diagnosed with Coronary Heart Disease before the age of 60.
_____1) None
_____2) 1 person
_____3) More than 1

2.0 Family history of Coronary Heart Disease occurring after 60 years old.
Indicate the number of members of your direct family (related by birth) who have died or been diagnosed with Coronary Heart Disease after the age of 60.
_____1) None
_____2) 1 person
_____3) More than 1

3.0 Family history of Diabetes.
Indicate the number of members of your direct family (related by birth) who have been diagnosed with diabetes.
_____1) None
_____2) 1 person
_____3) More than 1

4.0 Family history of Strokes or Cerebral Vascular Disease.
Indicate the number of members of your direct family (related by birth) who have died or been diagnosed with Strokes or Cerebral Vascular Disease.
_____1) None
_____2) 1 person
_____3) More than 1

5.0 Personal history of cancer
Have you ever been diagnosed with any type of cancer?
_____1) Yes
_____2) No

6.0 Personal history of heart disease
Have you ever been diagnosed with any form of heart disease?
_____1) Yes
_____2) No

Section B
Personal Health History and Habits

7.0 Colon/Rectal Screening
If you are over the age of 40, do you have an annual colon/rectal screening?
_____1) Yes
_____2) No
_____3) Not Applicable

8.0 PAP Smear
If you are a female over the age of 18, do you have an annual PAP smear?
_____1) Yes
_____2) No
_____3) Not Applicable

9.0 Mammogram Screening
If you are a female over the age of 35, have you had a mammogram within the past 2 years?
_____1) Yes
_____2) No
_____3) Not applicable

10.0 Prostate screening
If you are a male over the age of 40, have you had a prostate screening within the past 2 years?
_____1) Yes
_____2) No
_____3) Not applicable

11.0 Routine Health Screening
How often do you see your physician for routine check-ups or health screenings?
_____1) On an annual basis
_____2) At least every 2 years
_____3) Within the past 5 years
_____4) Not within the past 5 years

12.0 Cancer Warning Signs
Indicate if you have any of the following cancer warning signs.
_____1) Change in bowel or bladder habits
_____2) Chronic indigestion or difficulty in swallowing
_____3) Thickening or lump in breast or elsewhere
_____4) Unusual bleeding or discharge, a sore that does not heal
_____5) Change in freckle or mole
_____6) Persistent cough or sore throat
_____7) Unexplained weight loss
_____8) None

Section C
Alcohol/Caffeine/Tobacco Consumption

13.0 Consumption of alcohol
How often do you consume alcohol?
_____1) Never drink
_____2) 2 days or less per week
_____3) 3 days per week
_____4) 4 or more days per week

14.0 Number of alcoholic beverages
On the days you drink, on the average how many drinks do you have?
_____1) Never drink
_____2) 1 to 2 drinks
_____3) 3 to 4 drinks
_____4) 5 or more drinks

15.0 Caffeine
How often do you consume caffeine in your diet including coffee, tea, cola or chocolate?
_____1) Never
_____2) Occasionally but not every day
_____3) 1 to 3 servings daily
_____4) 3 to 5 servings daily
_____5) More than 5 servings daily

16.0 Smoking status
Indicate which of the following best represents your current status
NOTE: Check all that apply.
_____1) Have never smoked
_____2) Quit smoking less than 5 years ago
_____3) Quit smoking more than 5 years ago
_____4) Smoke pipe or cigar
_____5) Smoke less than 1 pack of cigarettes per day
_____6) Smoke more than 1 pack of cigarettes per day

17.0 Smokeless Tobacco
Do you use smokeless tobacco?
_____1) Yes
_____2) No

Section D
Exercise Program

18.0 Exercise Frequency
On the average, how many days per week do you exercise?
_____1) 3 or more days per week
_____2) Less than 3 days per week
_____3) No regular exercise program

19.0 Proper stretching
Do you perform stretching prior to exercise?
_____1) Always
_____2) Sometimes
_____3) Never
_____4) Currently not exercising

20.0 Warm-up and cool down
Do you warm-up and cool-down after exercising?
_____1) Always
_____2) Sometimes
_____3) Never
_____4) Currently not exercising

Section E
Nutrition Habits

21.0 Daily Meals
On the average how many meals do you consume per day?
_____1) 3 meals with "healthy" snacks
_____2) 3 meals
_____3) 2 meals or less
_____4) No regular eating pattern

22.0 Consumption of grain/bread products
On the average, indicate the type and amount of grain products you normally consume per day.
Note: A serving is 1 slice of bread, 1/3 cup beans / peas, 1/3 cup oatmeal, rice or other grain products. Choose the response that best describes your eating habits.
_____1) Whole grains at least 6 or more servings per day
_____2) Whole grains 6 servings or fewer servings per day
_____3) Refined grains such as white bread/rolls/processed flour at least 6 or more servings a day
_____4) Refined grains such as white bread/rolls/processed flour 5 or less servings per day
_____5) Rarely consume grain products

23.0 Consumption of vegetables
On the average, how many servings of vegetables do you consume per day? Note: A serving is approximately 1 cup of raw or 1/2 cup of cooked.
_____1) At least 3 to 5 servings per day
_____2) Less than 3 servings per day
_____3) Rarely consume vegetables

24.0 Consumption of fruits
On the average, how many servings of fruit do you consume per day? Note: A serving is approximately 1 piece of fruit.
_____1) At least 2 to 4 servings per day
_____2) Less than 2 servings
_____3) Rarely consume fruit

25.0 Daily consumption of dairy products
On the average, how many servings of dairy products do you consume per day? Note: A serving is approximately 1 cup of milk or 1 oz. of cheese.
_____1) At least 2 servings per day
_____2) Less than 2 servings
_____3) Rarely consume dairy products

26.0 Type of Dairy products
Indicate the type of dairy products you consume.
_____1) Nonfat selections only
_____2) Both low fat and nonfat about the same
_____3) Low fat only
_____4) Usually high fat selections
_____5) Do not consume dairy products

27.0 Daily consumption of meats and meat products
Indicate the type of meat you normally consume. Note: Choose the response that best describes your eating habits
_____1) Do not consume meat or meat products
_____2) Consume less than 6 oz. of low fat poultry or fish per day
_____3) Consume more than 6 oz. of low fat poultry or fish per day
_____4) Consume less than 6 oz. of high fat red meat per day
_____5) Consume more than 6 oz. of high fat red meat per day

28.0 Consumption of fats, dressings and spreads
Indicate the type and number of servings of fat, dressings and spreads you consume each day.
Note: High fat examples include butter, lard, and margarine, low fat examples include non-fat low-fat salad dressing, mayonnaise and cheese. Choose the response that best describes your eating habits. A serving is approximately 1 tablespoon.
_____1) Use low fat selections sparingly (less than 3 per day)
_____2) Use low fat selections frequently (3 or more per day)
_____3) Use both low fat and high fat about the same sparingly (3 or less)
_____4) Use high fat selections sparingly (less than 3 per day)
_____5) Use high fat selections (more than 3 per day)

29.0 Consumption of water
On the average, how many glasses of water do you consume per day? Note: A serving is one 8-oz. glass of water only; do not include coffee, soda or other beverages.
_____1) At least 8 glasses per day
_____2) About 4 to 8 glasses per day
_____3) Less than 4 glasses per day
_____4) Seldom consume water

30.0 Convenience and snack food consumption
On the average how many times per day do you eat convenience foods or forms of fast food?
_____1) Never
_____2) Less than 1 time per day
_____3) More than 1 time per day

Section F
Personal Health

31.0 Dental Check-up
Do you have an annual check-up with your Dentist?
_____1) Yes
_____2) No

32.0 Oral Health
Do you have any abnormal bleeding in your gums or around your teeth?
_____1) Yes
_____2) No

33.0 Eye Examination
How often do you see an eye specialist?
_____1) Once per year
_____2) Once every two years
_____3) Not within the last 2 years
_____4) No regular exams

34.0 Living Environment
Do you live or work in an environment, which you consider to expose you to pollution, either air, water or from your food?
_____1) Yes
_____2) No

35.0 Smoke Detector
Do you have at least one (1) working smoke detector for each floor of your home or apartment, which you check on a monthly basis?
_____1) Yes
_____2) No

36.0 Seat Belt Use
How often do you use your seat belt when either operating a motor vehicle or riding as a passenger?
_____1) Always
_____2) Sometimes
_____3) Never

37.0 Automobile Mileage
How many miles per month do you drive an automobile or ride as a passenger?
_____1) Less than 1000
_____2) Between 1001 to 1499
_____3) More than 1500 per month

38.0 Automobile Maintenance
If you own an automobile, do you have regular maintenance performed such as checking the tires, oil etc.?
_____1) Not applicable
_____2) Yes
_____3) No

39.0 Fire Protection
Do you have a working fire extinguisher in your home?
_____1) Yes
_____2) No

Section H
Osteoporosis

48.0 Osteoporosis
Have you ever been diagnosed with or indicated that you were at risk for Osteoporosis?
_____1) Yes
_____2) No
_____3) Not applicable

MetabolicRx Therapy
HEALTH RISK ANALYSIS

Section G
Lab Results

*** ***DO NOT COMPLETE THIS SECTION*** ***

BODY COMPOSITION: __________
CHOLESTEROL: __________ TRIGLYCERIDES: __________
HDL: __________ SYSTOLIC BP: __________
DIASTOLIC BP: __________ HEART RATE: __________
FASTING GLUCOSE: __________
Facilitator notes:
____
____
____
____
____
____
____
____
____
____
____

Name: ____ Date:
____