CORE Physical Therapy & Training
Coronavirus Disease 2019 Questionnaire
This information is highly confidential and will remain securely managed

You will be asked to complete this form at each visit or to verbally confirm that there have been no changes in your answers since the initial form completion.

Please check the **Yes** or **No** boxes; do not check both boxes. Feel free to explain what a yes or no answer means in the Comment Section below the question.

1) Have you traveled outside of the US in past 30 days? Yes ☐ No ☐
If yes, please list the countries you have visited below.
Comment:____

2) Have you had any of these symptoms? Yes ☐ No ☐
☐ Fever over 100.4°
☐ Persistent cough
☐ Shortness of breath
If yes, how long have you had these symptoms? ____________________
If yes, have you been diagnosed and/or seen the doctor? Yes ☐ No ☐
Comment:____

3) In the past 30 days, have you been in close contact with an individual who has traveled outside of the US?
Yes ☐ No ☐
If yes, please list the countries he/she has visited below.
Comment:____

4) In the past 30 days, have you been in close contact with an individual who has had any of these symptoms? Yes ☐ No ☐
☐ Fever over 100.4°
☐ Persistent cough
☐ Shortness of breath
If yes, have they been diagnosed and/or seen the doctor? Yes ☐ No ☐
Comment: ____

If you answered yes to any of the questions above, we will work with you to the best of our ability to make accommodations for therapy.

Should you have any questions or concerns, please contact a CORE team member at 541-500-8029. Thank you for assisting us in our endeavors to minimize exposure to the Coronavirus 2019.

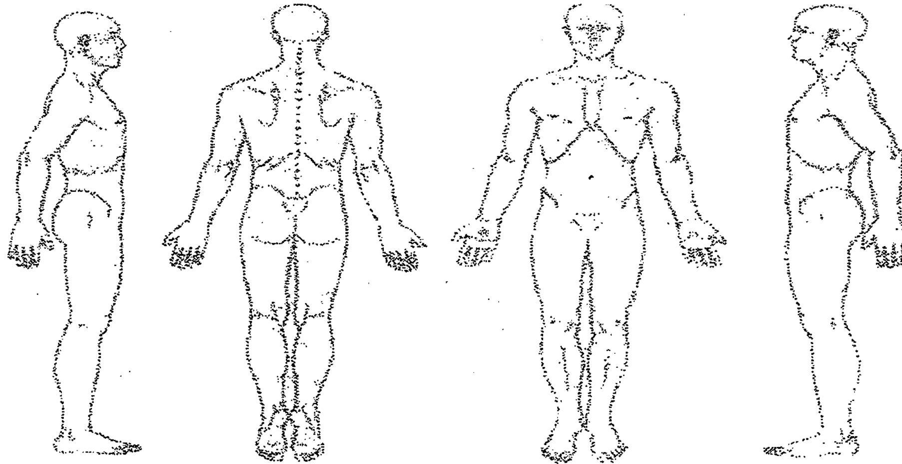
Name/signature:____________________________________ **Date:** ____________

CORE PHYSICAL THERAPY & TRAINING
PATIENT QUESTIONNAIRE

Name: ______________________ Birth date: __________ Date problem began: __________

Age: __________ Any falls within the last year? Yes or No Height: ______ Weight: ________

PAIN LOCATION **Use key at right to fill in body → → → → →**



o o o Numb

.... Pins & Needles

-------- Dull ache

x x x Moderate pain

Severe pain

Shooting pain

PAIN SEVERITY SCALE

0	1	2	3	4	5	6	7	8	9	10
None		Mild	Annoying Discomfort		Distressing Miserable		Agonizing Horrible		Excruciating Unbearable	

Choose the number of the word above that best describes the following:

____Your pain right now
____Your pain at its worst
____Your pain at its least

Frequency of Pain: Check one

_____Infrequent/Transient
_____Occasional
_____Constant/ Continuous

1. What is your present problem? ______________________________
2. How did this problem start? ______________________________
3. Please list anything you feel important or of interest to your current problem or pain:_______
4. Is your pain worse at any particular time of day? ___Yes. ___ No. If yes, when__________
5. What aggravates your pain? ___At rest ___Sitting ___Standing ___Awakens me ___Sneezing/Coughing ___Working ___Walking ___Sexual Intercourse ___All the time ___ Lifting ___Other (please specify)______________
6. What relieves your pain? ___Sitting ___Lying down ___Medications ___Heat ___Ice ___traction ___massage ___walking ___Other (please specify)______________
7. Do you have difficulty sleeping? ___ Yes ___No Sleep position ______________
8. At the present time are you getting: ___Better ___ Worse ____Stable
9. At the present time would you say your health is: __Excellent __Very good __ Fair __Poor
10. Do you have a Neurostimulator implant to control pain? ___Yes ___No

Please complete both sides

PATIENT QUESTIONAIRE

11. Do you (or have you recently) Suffered from any of the following?
    ___Numbness ___Malaise ___ Nausea/Vomiting ___ Dizziness
    ___Weakness ___Fatigue ___Fever/Chills/Sweats ___ Unexplained weight loss/gain
12. Are you or might be pregnant? ___Yes ___ No
13. Have you ever been diagnosed with or treated for any of the following conditions?
    ___Epilepsy/Seizures ___Liver disease ___Respiratory problems Type:______
    ___Osteoporosis ___Diabetes ___Heart Problems Type: _________
    ___Arthritis ___Thyroid problems ___Cancer Type: ______________
    ___High Blood Pressure ___Kidney problems ___Physical Disability
    ___Depression ___Neurological disorder (MS, stroke, Parkinson's) Other:_____
    ___Chemical Dependency (Alcoholism, Other) Other:______________________________
14. Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?
    ___Heart problems ___Diabetes ___Cancer ___ Headaches
    ___Stroke ___Mental illness ___Kidney Disease ___Liver Disease
    ___High Blood Pressure ___Osteoporosis ___Arthritis ___Physical Disability
15. Prior surgeries and approximate dates: ______________________________________
    ____
    ____
16. Have you seen any of the following medical personnel in the past 3 months?
    a. Doctor or nurse practitioner: ___ Yes ___No Reason: ______________________
    b. Osteopath: ___Yes ___No Reason: ______________________
    c. Chiropractor ___Yes ___No Reason: ______________________
    d. Psychiatrist/Psychologist ___Yes ___No Reason: ______________________
    e. Other Reason: ______________________
17. Have you had physical therapy before? __Yes __No If Yes, was it for your current problem? __Yes __No
18. What treatment during physical therapy helped? (exercise, manipulation, traction, cold/hot packs, etc.)
    ____
19. Recent Diagnostic Studies: __X-Rays __MRI __CT Scan __EMG __Ultrasound
    Results: ____
20. Type of medical equipment used at home or in the community (walker, cane, oxygen, etc.)___________
21. Leisure activities, sports, hobbies, exercise:______________________________________
22. Employment/Work (check all that apply): ___Full-time ___Part-time ___Light duty ___Unemployed
    ___Retired ___Student ___Homemaker ___Work with modification in job duty due to present problem
    ___Not working due to present problem
23. Occupation (title, type): ____
24. Where do you live (house, apartment, nursing home, etc.)? __________________________
25. With whom do you live (alone, spouse/significant other, child, etc.)?__________________
26. Do you drink caffeinated beverages? ___Yes ___No How many drinks per day? ___________
27. Any new life stresses? ____
    ____
28. Medications: **Please complete additional document.**

Please complete both sides

Center of Orthopedic Rehabilitation

Patient Information Form

Patient Information

Last Name ____________ First Name ____________ MI ____ SSN ____________

Address ____________

Address2 ____________ City ____________ State ____ Zip ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Date of Birth ________ Gender ____ Marital Status ________ Email ____________

Emergency Contact

Last Name ____________ Relationship ____________

First Name ____________ Phone ____________

Employer

Name ____________ Phone ____________

Address ____________

Address2 ____________ City ____________ State ____ Zip ____________

Problem

Problem Description ____________ Date of Injury ________ Last Physician Visit / / ________

Referred By ____________

Latest Referral Information ____________ Motor Vehicle Accident ____

Latest Plan of Care ____________ That occurred in: ____

Notes: ____________

Primary Insurance

Insurance ____________ Deductible ________

ID ____________ Max Benefit ________

Group # ________ CoPay ____ CoInsurance ________

Subscriber

Name ____________

Relationship ____________

Date of Birth ____________

Secondary Insurance

Insurance ____________ Deductible ________

ID ____________ Max Benefit ________

Group # ________ CoPay ____ CoInsurance ________

Subscriber

Name ____________

Relationship ____________

Date of Birth ____________

Tertiary Insurance

Insurance ____________ Deductible ________

ID ____________ Max Benefit ________

Group # ________ CoPay ____ CoInsurance ________

Subscriber

Name ____________

Relationship ____________

Date of Birth ____________

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: ______________________________ Date: ____________

The *difference* is in the *experience*
771 W Stewart Ave ~ Suite 103
Medford OR 97501
541-500-8029 (p)
541-622-8337 (f)

FINANCIAL RESPONSIBILTY

It is our intent to make the financial side of our services as understandable as possible. Please read the information below and indicate your acceptance with your signature.

YOUR INSURANCE BENEFITS

Your insurance policy is a contract between you and your insurance company. It is important that you fully understand your coverage. We cannot accurately predict what will be paid for services rendered. As a courtesy, we will contact your insurance company, however, we are unable to assume responsibility for the accuracy of information supplied by them. We strongly suggest you contact your insurance provider to be advised of details regarding your physical therapy coverage prior to your first visit. Please read the explanation of benefits forms you will receive from your insurer to verify and ensure treatments are covered. Call your insurer with any questions you may have regarding the processing of claims. **We recommend you keep track of the number of visits and pre-authorization requirements that may limit or affect your treatment with us.**

BILLING POLICIES

Per industry standards, **CORE Physical Therapy & Training (hereafter CORE)** will bill your insurance company, however, you ultimately assume financial responsibility for all charges incurred as a result of professional services provided. You agree to assign all payments for services rendered to **CORE**. Once we have received payment from your insurance provider, you will receive a detailed statement including any account balance. Any left-over balance (the amount NOT covered by insurer) will be reflected on statement and is your responsibility. Account balances are due within 14 days of billing date. After 90 days, all unpaid balances will incur a 12% interest fee per annum, until paid in full. Returned check fee is $25. If you need to set up a payment plan, please contact us to discuss options.
CORE reserves the right to charge a $35 fee for no-show appointments or cancellations without 24 hour notice. _______(please initial)

ACCEPTANCE & AGREEMENT

I consent to care as provided at **CORE**. I accept full financial responsibility and agree to work with **CORE** to ensure clinic is paid for services they provide to me. I will pay balances as claims are processed.

Signature of patient or responsible party:

____ **Date**_________________________

****Agreement remains in effect until revoked in writing****

Medication List

{please include prescriptions, over the counter, herbal supplements etc...}

Drug Name	Dose/ Frequency	Delivery Route (please check one)			
		Oral	Topical	Injection	Other (specify)
1-__________	__________				
2-__________	__________				
3-__________	__________				
4-__________	__________				
5-__________	__________				
6-__________	__________				
7-__________	__________				
8-__________	__________				
9-__________	__________				
10-__________	__________				
11-__________	__________				
12-__________	__________				
13-__________	__________				
14-__________	__________				
15-__________	__________				
		please use reverse for any additional medications			

Please initial appropriate box:

☐ **This <u>is</u> a complete list of my medications at this time. I will notify my therapist if there is a change to this list.**

☐ **This <u>is not</u> a complete list of my medications.**

Print Name:______________________________

Signature:____________________ **Date:**____________

CORE Physical Therapy & Training
Acknowledgement of Notice of Privacy Practices/HIPAA Authorization

(To be retained by Medical Provider)

I understand that CORE Physical Therapy & Training (referred to below as "the clinic") will **use and disclose my health information** in the course of providing physical therapy care to/for me.

I understand that my **health information** may include information both created and received by the clinic, that it may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions and/or similar health-related information.

I understand that the clinic is permitted to **use and disclose** my **health information** in order to:

- Make decisions about and plan for my care and treatment
- Refer to and/or consult with other health care providers during the course of my treatment
- Determine my eligibility for health plan or insurance coverage and submit bills, claims, and other information to insurance companies or other party responsible for payment
- Perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment

I understand that the Notice of Privacy Practices/HIPAA Authorization may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices/HIPAA Authorization upon request, and that a copy or summary of the most current version of the clinic's Notice of Privacy Practices/HIPAA Authorization in effect will be available in waiting/reception area.

I understand that the Notice of Privacy Practices/HIPAA Authorization describes how I can exercise my right to ask that some or all of my **health information** not be used or disclosed, and I further understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have received or have been offered a copy of the clinic's Notice of Privacy Practices/HIPAA Authorization.

Signature: ______________________________ **Date:** ____________________
(Patient)

-OR-

Authorized Signature: ______________________________ **Date:** ____________________
(Patient Representative/
Relationship)

For Office Use Only

The clinic attempted to obtain written acknowledgment of receipt of the clinic's Notice of Privacy Practices/HIPAA Authorization, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication variant prohibited the clinic from obtaining
- ☐ An emergency situation prohibited the clinic from obtaining
- ☐ Other (*please specify*)

Important CORE Policies For a Successful Relationship

We strive to provide you with the best personalized care available. To ensure this, we adhere to a set of mutually beneficial and important guidelines. Please read carefully and initial each line.

__________ **Late Policy: 15 minutes**
Arriving more than 15 minutes after your scheduled appointment time will require you to reschedule

__________ **24-Hour Cancellation Notice Fee**
If you are unable to keep your appointment, please provide a 24-hour advance notice in order to allow time for us to schedule another patient in your place. Anything less will result in a $35 fee

__________ **Copays Due Upon Arrival**
Copays are due at the time of your appointment

__________ **No Shows**
No shows are not good for anyone, so please be courteous and responsible by properly communicating via phone call, voicemail or email

__________ **Cell Phones**
We realize emergencies may arise, however, please be courteous and set your phone to silent during your appointment time

__________ **Children Requiring Supervision**
For liability purposes, we do not allow unattended children in the gym or treatment areas

__________ **Financial Hardship**
Please speak with a CORE team member if you are experiencing financial difficulties or need to make payment arrangements

__________ **Image Release**
We would like to share your success at CORE with our local community. We ask for your permission to use your likeness in photographs and/or your written review or testimonial on our website

Thank you for your consideration ... we look forward to building a successful relationship that lasts a lifetime!