



## Southside Physical Therapy – Pain Assessment

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Occupation \_\_\_\_\_ Work Type: Sedentary \_\_\_ Light Manual \_\_\_ Heavy Manual \_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Please List Previous Surgeries, Major Illnesses and Current Medical Conditions: \_\_\_\_\_

Have you had any falls in the last 1 year? \_\_\_ Yes \_\_\_ No    Were you injured in the fall? \_\_\_\_\_ Yes \_\_\_\_\_ No

### Pain Rating – Rate your pain levels using the 0 – 10 scale below, to indicate the intensity of your pain.

Your Pain	0-10 SCALE OF PAIN SEVERITY	
(During the last 30 days use pain scale on the right.)	<b>Severity</b>	Description of pain when pain is present
	0	No Pain Pain Free.
	1	Minimal Pain is hardly noticeable.
Pain Rating at this moment _____	2	Mild Feel a low level of pain; aware of pain only when paying attention to it.
	3	Uncomfortable Pain is troubling but can be ignored most of the time.
	4	Moderate Constantly aware of the pain but can continue normal activities.
Least amount of pain _____	5	Distracting Pain is barely tolerable; some activities limited by pain.
	6	Distressing Pain preoccupies thinking; must give up many activities due to the pain.
	7	Unmanageable Constant pain that interferes with almost all activities; often must take time off work; nothing seems to help.
	8	Intense Severe pain makes it hard to concentrate on anything but the pain; conversation difficult.
Worst Pain: (most amount of pain) _____	9	Severe Can concentrate on nothing but the pain; can do almost nothing; can barely talk.
	10	Immobilizing Pain is excruciating. Unable to move except to seek immediate help for pain in emergency room. Bedridden.
	KP Northwest	

**Functional Rating:** List three functional activities or positions most limited by **THIS EPISODE**: (eg: sitting, sleeping, standing walking, lifting, fixing your hair, getting up from a chair, putting on shoes or pants, getting in and out of a car, turning over in bed, etc) Then score each activity limitation from 0-10.    0 = no difficulty 10 = unable to perform activity,

Activity:	Score from 0 - 10
1.	
2.	
3.	

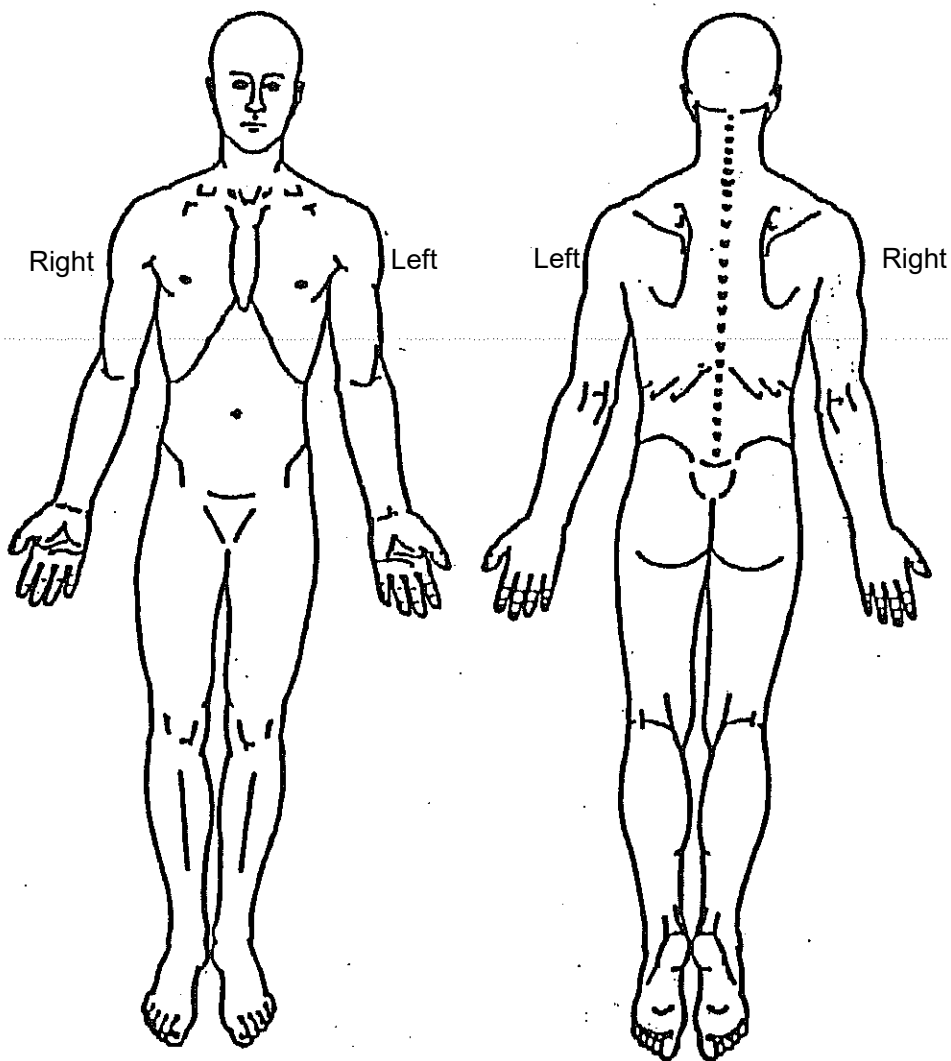
**GOALS:** Please list 3 goals you would like to achieve with your treatment.

1.
2.
3.

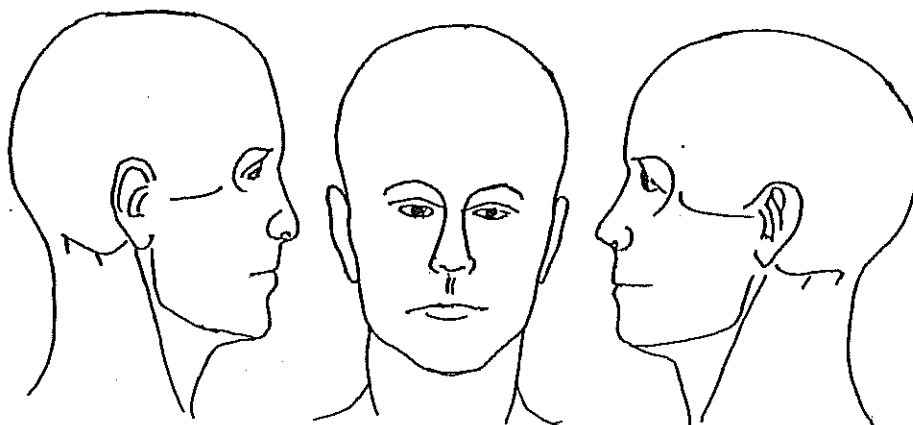
**Please complete the Symptom diagram. Thank you.**

Please use the symbols below to describe your symptoms related to this current injury or condition.

/// Pain    xxx Burning    000 Pins and Needles    === Numbness    +++ Swelling



HEADACHES & JAW PAIN



PATIENT REGISTRATION / RESPONSIBLE PARTY AGREEMENT

**Please read carefully and check each box:**

- I consent to treatment by a physical therapist.
- I specifically authorize the release of physical therapy records and physicians' orders for therapy to the parties and insurance I have provided.
- I authorize Southside Physical Therapy, Inc. to bill my insurance company and to furnish information to them concerning my treatments.
- I assign to Southside Physical Therapy, Inc. all payments for services rendered to me or my dependents.
- I understand that I am responsible for any amount not covered by insurance.
- I understand that I am responsible for charges and fees for items and services not covered by insurance.
- Co-pays are due at the time of service.
- Patient and insurance balances are due upon receipt of the first statement and need to be paid prior to the next appointment unless other arrangements have been made.
- I understand at the end of my treatment, a representative of Southside Physical Therapy will offer either a 4-month, interest free equal payment option or an application for Care Credit as Southside Physical Therapy is a small office and cannot carry long term patient balances.
- My health insurance may also require a referral for Physical Therapy. If the referral is not presented at my first appointment, I understand my insurance may deny all charges and I will be financially responsible.
- I understand there will be a \$25.00 charge for the first appointment canceled with less than 24 hour notice, and \$50.00 for the second late cancellation with a possible discharge from Physical Therapy.
- I understand that there is a \$25.00 charge for arriving over 15 minutes late to an appointment.
- I understand there is a \$35.00 charge for non-sufficient fund checks (NSF).
- I have received or been offered a copy of this office's Notice of Privacy Practices (HIPAA NPP).
- I authorize the office to leave messages concerning treatment, appointments/scheduling and financial information via text, voice mail or email.

***Sampson Physical Therapy Inc, dba Southside Physical Therapy bills your insurance as a courtesy to you. We strongly recommend that you verify your benefits with your insurance company.***

I, \_\_\_\_\_ (patient or responsible party), acknowledge that I **have read** and understand the statements above and that I **am responsible for charges to my account** at Southside Physical Therapy, Inc. I promise to pay for services and supplies provided within the payment and credit policies set forth by Southside Physical Therapy, Inc. I have been informed Sampson Physical Therapy; Inc dba Southside Physical Therapy does not carry patient balances for longer than 4 months. If my account is placed in the hands of an attorney for collection or turned over to any agency for collection, I/we agree to pay all reasonable attorney fees even if no suit or action is filed thereon. Accounts assigned to a collection agency will be charged a one-time collection fee of \$50 plus 9% of the outstanding principal balance at the time of assignment.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

# Medication List

Please List ALL medications, Vitamins, and Supplements

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

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Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please Note: An updated list of medications is needed at every new patient visit, even if you are returning.