# WHITE SANDS PHYSICAL THERAPY & AQUATICS

## MEDICAL HISTORY

**Patient Last Name**: _____ **First Name**: _____ **DOB:** _____

Primary Care Physician: _____

Referring Physician or name of the doctor who will be signing any reports generated by your therapist: _____

Diagnosis or reason for Physical or Occupational Therapy_____

## Check all current or past conditions:

| | | | | | |
|---|---|---|---|---|---|
| Back Pain | ☐ | Fibromyalgia | ☐ | Tingling in Legs/Feet | ☐ |
| Spinal Stenosis | ☐ | Hysterectomy | ☐ | Total Knee Replacement | ☐ L ☐ R |
| Back Surgery | ☐ | Balance | ☐ | Total Shoulder Replacement | ☐ L ☐ R |
| Disc Problems | ☐ | Pregnant | ☐ | Total Hip Replacement | ☐ L ☐ R |
| History of Sciatica | ☐ | Asthma | ☐ | Cancer: Type_____ | ☐ |
| History of Scoliosis | ☐ | COPD | ☐ | Fear of swimming pool | ☐ |
| Knee Pain | ☐ | Shortness of Breath | ☐ | Open Wound/Sore | ☐ |
| Hip Pain | ☐ | Anxiety | ☐ | Skin Rashes | ☐ |
| Shoulder Pain | ☐ | Depression | ☐ | Osteoarthritis (Degenerative) | ☐ |
| Neck Pain | ☐ | Memories Issues | ☐ | Rheumatoid Arthritis | ☐ |
| Neck Stiffness | ☐ | Dementia | ☐ | Osteoporosis | ☐ |
| Chest Pain | ☐ | Alzheimer | ☐ | Osteopenia | ☐ |
| Heart Disease<br>Heart Surgery | ☐<br>☐ | Diabetes | Type 1 ☐<br>Type 2 ☐ | Anemia | ☐ |
| Pacemaker / Defibrillator | ☐ | Hypoglycemia | ☐ | Infection Disease | ☐ |
| CVA Stroke | ☐ | Thyroid | Hypo ☐<br>Hyper ☐ | Vision Problems | ☐ |
| High Blood Pressure | ☐ | Bladder Urgency | ☐ | DNR | ☐ |
| Low Blood Pressure | ☐ | Bladder Incontinence | ☐ | Metal Implant | ☐ |
| Parkinson | ☐ | Bowel Urgency | ☐ | | |
| Headaches | ☐ | Bowel Incontinence | ☐ | | |
| Epilepsy or Seizure | ☐ | Peripheral Neuropathy | ☐ | | |
| Dizziness/Fainting | ☐ | Tingling in Arms/Hands | ☐ | | |
| Falls (last fall date) | ☐ | Hearing Problems | ☐ | | |

***Staff Initials: ____***
***Rev. 09.13.22***

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*Sarasota, FL 34231*

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**Patient Last Name**: _____ **First Name**: _____ **DOB:** _____

Do you live alone? ☐ Yes ☐ No Living partner disabled? ☐ Yes ☐ No

Do you smoke or use other Tobacco Products? ☐ Yes ☐ No

**Height:** _____ Feet _____ Inches **Weight:** _____ Pounds

We recommend that you consult with your general practitioner about any weight management question. **Patients Initials:_____**

SURGERIES: Please list with Date and Details:

_____

_____

_____

_____

OTHER HEALTH ISSUES (Including Chronic Conditions):

Please list: _____

_____

_____

_____

_____

ALLERGIES:

Please list:_____

_____

☐ I have listed all my medical conditions to the best of my knowledge.

☐ I attest that the information provided by me on this medical history form is correct.

_____ _____

**Patient Signature** **Date**

***Staff Initials:*** ____

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# WHITE SANDS PHYSICAL THERAPY & AQUATICS
# MEDICATIONS LIST

**Patient Last Name**: _____ **First Name**: _____ **DOB:** _____

Please provide us with a complete list of your medications for our files. Please include any Over the Counter medications, Vitamins or Herbal Supplements you may be taking. If you need a second page, please let us know.

***Please also list any OTC pain or anti-inflammatory medications even if only taken as needed. (ie: Tylenol, Advil, Motrin, Aleve, etc)***

| | Prescription/Over the Counter/Vitamins Supplements/Herbal Supplements | Dosage | O - Oral<br>I - Injection<br>C - Cream<br>S - Sublingual | Times per day. If only used as needed circle PRN | What is it used for? (i.e.: heart, Blood pressure, kidney) |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |
| 11. | | | | | |
| 12. | | | | | |

Check if apply:

☐ I am currently not using any medications.

☐ Please see my list of medications provided on separate page.

☐ I verify that the above list of medications/Supplements is correct and contains all that I am currently taking.

_____ _____

**Patient Signature** **Date**

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# WHITE SANDS PHYSICAL THERAPY & AQUATICS
# PATIENT DEMOGRAPHICS

**PATIENT INFORMATION** (Please Print)

**Patient Last Name**: _____ **First Name**: _____ **Middle Initial**: _____

Date of Birth: _____ Social Security #: _____ Gender: ☐ Male ☐ Female

Home Phone: _____ Other Phone: _____

Address: _____ City: _____State: _____ Zip: _____

Out of State Address & Phone #: _____

**EMERGENCY CONTACT**

Name: _____ Home/Cell Phone: _____

Relationship: _____

**Electronic Communication:**

White Sands Physical Therapy & Aquatics believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from White Sands Physical Therapy & Aquatics via email or text messaging. White Sands Physical Therapy & Aquatics does not share the names, e-mail addresses, and/or telephone numbers of patients with any other company, or with any other patient.

Email: _____ Cell Phone: _____

I reviewed the information and made any necessary changes.

**Authorization to discuss your care with Family or Friends**

White Sands Physical Therapy & Aquatics is authorized to discuss health, appointment and/or billing information pertaining to the above patient to the entities below.

- Leave information on voice mail: Home ☐ Cell ☐ Work ☐
- Share information to _____ Relationship: _____
- Share information to: _____ Relationship: _____

White Sands Physical Therapy will bill your insurance as a courtesy to you; however, if no payment is received from your insurance within 45 days of billing, payment in full will be expected from you. I hereby authorize my benefits, including Medicare, to be paid directly to White Sands Physical Therapy and authorize the release of medical information necessary to process claims.

_____ _____

**Patient Signature** **Date**

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# WHITE SANDS PHYSICAL THERAPY & AQUATICS

**Patient Last Name**: _____ **First Name**: _____ **DOB:** _____

## PHYSICIAN

Date of Next Appointment with Referring Physician: _____

**Have you received any physical, occupational or speech therapy in this calendar year?** Yes ☐ No ☐

How many visits: _____Place of service: _____ Date of last visit: _____

What area(s) of the body was treated? _____

**Have you had Home Health Care in the past 60 day?** Yes ☐ No ☐ How many visits: ____

Have you been Discharged? Yes ☐ No ☐ If yes, Date of Discharge: _____Agency that provided care: _____

## Please Read & Initial:

*** Medicare will not pay for Outpatient Physical Therapy if patient is receiving any type of Home Health Care. This includes Home Health Nursing, Home Health Respiratory, Home Health Aide, and/or any other type of Home Health Care. It is the patient's responsibility to inform the Therapist or office staff if the patient is currently under Home Health Care. If WSPTA is denied payment because of Home Care Services, then the patient is responsible for the full cost of care provided by WSPTA. Patients Initials: _____**

*** Patient that are scheduled to go in the pool, please be aware, NO OPEN WOUNDS IN THE WATER. If you are to have a biopsy done you will not be able to go into the pool for two weeks after having a biopsy and a written release from your MD will be required to resume pool treatment. We request that for your benefit, all biopsies be scheduled after you have completed therapy (unless otherwise noted by your doctor). Patients Initials: _____**

*** WSPTA strives to provide the best therapy in the area, any changes in your health while enrolled in our program makes a difference in your care. Please report any falls or injury immediately, your therapist will need to evaluate your condition to make sure that is safe to continue treatment. In the case of a serious injury or fall, a Doctor's note may be required to resume treatment. Patients Initials: _____**

***Health disclaimer: I attest that as of today, I am not experiencing any symptoms of illness suggesting a Cold, flu or Covid-19 infection. I acknowledge White Sands Physical Therapy and Aquatics efforts in keeping the patients and staff safe by following and implementing CDC guidelines. I will promptly inform White Sands Physical Therapy and Aquatics if I become ill or come in contact with someone sick or positive for Covid-19, or if I myself, test positive for COVID-19.**
**Patients Initials: _____**

## ACCIDENT:

**Are your symptoms related to an accident?** Yes ☐ No ☐

**Auto Accident?** Yes ☐ No ☐ **Work Related Accident**: Yes ☐ No ☐

**Accident Date:** _____ Claim No.: _____

Adjuster Name: _____ Phone No.: _____

**Is the Case Settled?** Yes ☐ No ☐ **Is there or will there be a legal matter in this case?** Yes ☐ No ☐

**If yes:** Attorney: _____ Phone No.: _____

**I attest that the information provided by me on this patient information form is correct.**

_____ _____

**Patient Signature** **Date**

***Staff Initials:*** ____

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# WHITE SANDS PHYSICAL THERAPY & AQUATICS

**Patient Last Name**: _____ **First Name**: _____ **DOB:** _____

## Acknowledge of Receipt of Notice of Privacy Practices

I have received or have been offered a copy of the Notice of Privacy Practices from White Sands Physical Therapy & Aquatics.

_____ _____

**Patient Signature** **Date**

## Authorization for treatment, Acknowledgement of Financial Responsibility and Assignment of Benefits

I acknowledge that I am legally responsible for all charges in connection with the medical care, treatment and therapy provided by representatives and personnel of White Sand Physical Therapy & Aquatics, LLC. I consent to the release of any medical information, including diagnosis and the records of any treatment or examination rendered to me for such services to third party payers, health care practitioners and/or managed care organizations. I hereby assign, authorize, and direct payment of my medical benefits to White Sands Physical Therapy & Aquatics, LLC. I understand that White Sands Physical Therapy & Aquatics, LLC will assist me in submitting my claims to my insurance carrier. I understand my insurance carrier may not approve or reimburse my medical services in full due to benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. Furthermore, any information given to us may be used for the collection of payments for services provided. **I give permission for White Sands Physical Therapy and Aquatics to give me Physical and/or Occupational Therapy Treatment.**

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my therapist.

_____ _____

**Patient Signature** **Date**

## NO SHOW AND CANCELLATION POLICY

An appointment with a White Sands Physical Therapy and Aquatics therapist reserves a period of time for you. A cancelled appointment or a no show keeps others from having access to that therapist.

- We require at least 24 hours' notice of cancellation in advance of your scheduled appointment.
- All no shows and late cancellations for appointments will be charged $50.00 for any missed appointment (that includes any portion of your treatment cancelled at the last minute).
- Please cross check your White Sands schedule against your calendar at home for any conflict that would result in a cancellation fee.
- This fee must be paid prior to receiving future services.
- Chronic Cancellations will cause to cancel all patients schedule.
- Medical insurance cannot be billed for missed appointments.
- I understand that I must call to cancel my appointment 24 hours prior to my scheduled appointment time. **There will be a $50.00 No call/No show fee assessed when notification is not given for a missed appointment without 24 hours' notice.**

I have read, understand, and agree with the provision of this cancellation policy.

_____ _____

**Patient Signature** **Date**

***Staff Initials:*** ____

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# WHITE SANDS PHYSICAL THERAPY & AQUATICS

**Patient Last Name**: _____ **First Name**: _____ **DOB:** _____

## Geriatric Depression Scale

**Please circle YES or NO. Circle the best answer for how you have felt over the past week:**

| | | | |
|---|---|---|---|
| 1 | Are you basically satisfied with your life? | Yes | No |
| 2 | Have you dropped many of your activities and interests? | Yes | No |
| 3 | Do you feel your life is empty? | Yes | No |
| 4 | Do you often get bored? | Yes | No |
| 5 | Are you in good spirits most of the time? | Yes | No |
| 6 | Are you afraid that something bad is going to happen to you? | Yes | No |
| 7 | Do you feel happy most of the time? | Yes | No |
| 8 | Do you often feel helpless? | Yes | No |
| 9 | Do you prefer to stay at home, rather than going out and doing new things? | Yes | No |
| 10 | Do you feel you have more problems with memory than most? | Yes | No |
| 11 | Do you think it is wonderful to be alive now? | Yes | No |
| 12 | Do you feel pretty worthless the way you are now? | Yes | No |
| 13 | Do you feel full of energy? | Yes | No |
| 14 | Do you feel that your situation is hopeless? | Yes | No |
| 15 | Do you feel that most people are better off than you are? | Yes | No |

## Elder Abuse Suspicion Index

**Please circle YES or NO. You do not have to answer these questions if you do not want to.**

| | | | |
|---|---|---|---|
| 1 | Do you rely on people for any of the following: bathing, dressing, shopping, banking, or meals? | Yes | No |
| 2 | Has anyone prevented you from getting: food, clothes, medication, glasses, hearing aids medical care, or from being with people you wanted to be with? | Yes | No |
| 3 | Have you been upset because someone talk to you in a way that made you feel shamed or threatened? | Yes | No |
| 4 | Has anyone tried to force you to sign papers or to use your money against your will? | Yes | No |
| 5 | Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? | Yes | No |

Patient Name: _____
**(Please Print)**
Patient Signature: _____

Patient refused to fill out in part or in full _____



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# WHITE SANDS PHYSICAL THERAPY & AQUATICS

## Pain Scale

**Patient Last Name**: _____ **First Name**: _____ **DOB:** _____

**Pain scale**: Please indicate your **worst pain levels in the past week**. This worst pain may be only minutes per day OR it may last much longer. You will be asked your worst pain level at every visit so be ready to answer. We would also like to know your pain level when you feel your best and your average pain.

**Onset date.** Insurance companies want to know when you're pain/problems started or when it became significantly worse. You probably won't know the exact date, but we need an estimate of your onset date.

Onset Date: _____

Please indicate your **worst pain levels in the past week.**

☐ 0 No Pain, No Discomfort, no Aching, I feel perfectly normal.

☐ 1 Hardly noticeable Pain. Can do all my normal activities. With activities I do not notice my pain.

☐ 2 Low level Pain which I am only aware of it when I pay attention to it. Can do all my normal activities.

☐ 3 Still mild, Uncomfortable. I can ignore this pain most of the time.

☐ 4 Mild plus Pain. Although I am constantly aware of my pain, I can continue most of my activities.

☐ 5 Moderate Pain. I think about my pain most of the time. I can only do activities that must be done.

☐ 6 Moderate Plus Pain; Distressing. I think about my pain all of the time. I give up many activities due to pain.

☐ 7 Low level Severe Pain. This pain keeps me from doing most of my activities.

☐ 8 Severe & Intense Pain. Pain is so bad I can hardly think of anything else. Talking and listening or difficulty.

☐ 9 Extremely Severe Pain. My pain is all I can think about. I can barely talk or move because of pain.

☐ 10 Excruciating Pain. In bed and can't move due to pain. I need someone to take me to the emergency room



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