American Headache Institute

Thank You for choosing American Headache Institute!

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*This is your **New Patient Packet** and instructions.*

Please fill out the forms below electronically. When you are finished filling out your forms, please print them off and bring them with you to your first appointment.

1. *Electronically fill out each blue field that is blank.*
2. *You can answer the questions by checking the appropriate box or filling in your answer with the space provided.*
3. *Print the completed forms.*
4. *Sign each form that requires the patient/guardian signature.*

If you prefer to print these forms and fill them out by hand, you are welcome to do so.

Thank you for choosing American Headache Institute. We look forward to working with you!

www.americanheadacheinstitute.com

Patient's Name: Account #: Case: PT

CONSENT FOR CARE AND TREATMENT

I give my consent for American Headache Institute to furnish medical care and treatment considered necessary and proper in treating my physical condition.

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

All information provided herein is true and correct. I give permission to American Headache Institute to release/obtain information, verbal and written, contained in my medical record, and other related information, to/from my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related person, as needed. I authorize direct payment to American Headache Institute for services provided.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she has been personally advised that copies of American Headache Institute's Notice of Privacy Policies are posted at the point of care and that copies are available upon request.

PAYMENT GUARANTEE

In consideration for the services rendered and/or to be rendered to myself or dependent named above by American Headache Institute, I expressly guarantee payment of the account and agree to pay any charges left unpaid in whole or in part by the insurance company. **I acknowledge that I am responsible for all account totals and balances. I promise to notify American Headache Institute if at any time there is a change in my insurance eligibility and/ or benefits.**

In regards to the Cash Based Physical Therapy Packages & Sessions: I realize all sales are final and no refunds will be issued. I understand packages do not expire, and can only be redeemed at the original location of purchase and that any unused sessions are transferrable to family/friends at the original location of purchase *only.*

Worker's Compensation Patients: The above does not apply for those patients that are covered by Worker's Compensation. However, be advised as a Worker's Compensation patient that you may be held responsible for your charges in the event that your claim is denied. **Medicare Patients: You may not access Home Health Care Benefits and attend our clinics during the same period of time; Out-Patient Physical Therapy is not a covered benefit during any Home Health Care treatments. Other Commercial Insurance Patients**: Many plans limit the number of visits you may receive per calendar/benefit year. This information is provided to you only as a summary of benefits and is not a waiver of your payment guarantee or an explanation of your benefits. Patients must contact their insurance company for full "disclosure" of benefits. **All Insurance Patients:** It is your responsibility to provide American Headache Institute with a valid prescription for treatment. If American Headache Institute does not receive a valid prescription, services cannot be rendered.

I certify all information given on my intake forms is accurate. I certify that I have read and fully understand all the above consents. If the patient or insured is a minor, their parent or guardian must sign below. A photocopy of this authorization shall be acceptable as the original.

Patient Signature (Parent/Guardian if under 18) Date

Witness Signature Date

Revised 04/08/15

American Headache Institute

Account#:_____
CasePT_____
Location:AHI_____
First Visit:AHI_____

Patient Name:_____**Doctor:** _____

1. I am a previous patient at AHI ***(if Yes, skip to #4.)*** ☐ **YES** ☐ ☐ **NO**

2. Who can we thank for referring you to AHI? (Please check one)

☐ Doctor/Dr's Staff ☐ Family/Friend ☐ Employee ☐ Athletic Trainer ☐ No one

3. If you checked "No one" how did you hear about AHI? (Please check one)

☐ Expo/Event ☐ Internet/Website ☐ Newspaper/Magazine ☐ Sign ☐ Other/Detail _____

If you indicated in Question #2 that someone referred you to us, please provide the following information so that we can thank them!

Name : _____ Address: _____

City: _____ Zip: _____ ☐ **Marketing > Enter into Raintree**

4. Courtesy Appointment Reminders & Missed Appointment Policy

American Headache Institute offers courtesy appointment reminders via Text Message or E-mail one day prior to your next scheduled appointment. If you cannot make your scheduled appointment, we ask that you call us at least **24 hours** in advance to reschedule your appointment. If you fail to call 24 hours in advance to reschedule or cancel your appointment, American Headache Institute reserves the right to bill your account a **$25.00 missed appointment fee.**

Please select one option below on how you would like to receive your courtesy appointment reminders:

☐ **Text Message - Cell Phone (_____)_____ -- _____ Carrier:_____**
☐ **E-Mail - _____@_____.COM**

_____ _____ _____
PATIENTS NAME PATIENTS SIGNATURE DATE

Primary Referral Source_____ _____ (CD initials) Gift Card ☐ YES ☐ NO

American Headache Institute

Patient Name: _____ **Account #:** _____ **Date:**_____

By taking the time to complete this form, you will be assisting us in planning your physical therapy treatment. Please be as thorough as possible. If there is information relevant to your treatment not outlined below, please bring it to the attention of your physical therapist. Your cooperation is greatly appreciated.

Current Condition(s)/Chief Complaint(s)

Reason for referral to physical therapy: _____

Date of injury or onset of the problem: _____

Is this injury due to a motor vehicle accident? ____ Yes ____ No **Work related accident?** ____Yes ____No

If yes to either, please see our front office receptionist.

Location of pain: _____

Is your current pain: Intermittent ☐ **Constant** ☐

Do you have any of the following symptoms: Numbness ☐ **Tingling** ☐

Have you experienced any of the following?

Changes in bowel or bladder function ☐
Non-healing sores or wounds ☐
Pain that is worse during rest vs. activity ☐
Fatigue ☐
Fever/Sweats ☐
Unexplained significant lower or upper limb weakness ☐
Pain that is worsened at night or not relieved by any position ☐
Unexplained weight loss ☐
Referred or radiating pain ☐

Have you received physical therapy in the past 12 months? ____ Yes ____ No

If yes, where and for what? _____

Please describe the treatment: _____

Functional Status and Activity Level

Prior to the condition or injury, please rate your functional status with self-care and home management activities:

Excellent ☐ Good ☐ Fair ☐ Poor ☐

Please rate your current functional status with self-care and home management activities:

Excellent ☐ Good ☐ Fair ☐ Poor ☐

Family/Social History

Do you live alone? ____ Yes ____No **If No, with whom do you live?** _____

Are you currently working? ____Yes ____ No **What is your occupation?** _____

Pertinent Family History _____

Living Environment

In which type of home do you live? ☐ 1-story home ☐ 2-story home ☐ Apartment ☐ Tri-level Other: _____

Are there stairs in the home or in order to get into the home? ____ Yes ____ No

If yes, number of steps: ____ Hand Railing present on: ☐ Right side ☐ Left side ☐ Both sides ☐ No hand railing

General Health Status

Height _____ **Weight:**_____

What type of exercise or activity did you participate in prior to this condition? _____

_____

How often did you participate in this activity or form of exercise? ☐ 5-7 times per week ☐ 3-5 times per week ☐ 1-2 times per week ☐ 1-2 times every other week ☐ Once per month ☐ Other Please Specify: _____

Do you smoke? ☐ Yes ☐ No If yes: less than 1 pack per day ☐ or more than 1 pack per day ☐

How often do you drink alcohol? ☐ Zero ☐ Less than 1 day ☐ 1-2 days ☐ 3-4 days ☐ 5-7days

Are you pregnant? ____ Yes ____ No **Physician:** _____

Patient Name _____ **Account #** _____

Medical/Surgical History

Have you ever been diagnosed as having any of the following conditions? (Please check yes or no in box)

	YES	NO	PT Comments		YES	NO	PT Comments
Osteoporosis				Have a Pacemaker			
Cancer				Hearing or Visual Impairment			
Diabetes				Thyroid Problem			
Arthritis				Kidney Disease			
High Blood Pressure				Vertigo			
Circulatory Problems				History of Falls			
Depression				High Cholesterol			
Seizures				Contagious Diseases			
Heart Problems				Stroke			

Please list any other injuries or diagnoses if not indicated above: _____

Have you ever had surgery? _____ Yes _____ No

If yes, please list what type and the date(s)? _____

What activities has your doctor instructed you to limit or avoid? _____

Medications

Are you currently taking any over-the-counter medications, vitamins, or herbal supplements? _____ Yes _____ No

If yes, please list which ones: _____

Have you had a flu shot recently? _____ **Yes** ____ **No If yes, when:** _____

Are you currently taking any of the following Medications (please check box and indicate name):

Corticosteroids		Name:	Antibiotics		Name:
Pain Relievers		Name:	Birth Control Pills		Name:
Insulin		Name:	Muscle Relaxers		Name:
Seizure Medication		Name:	Diuretics		Name:
Aspirin		Name:	Tylenol/Acetaminophen		Name:
Anti-Inflammatory		Name:	Heart Medications		Name:
Decongestants		Name:	Antidepressant		Name:
Sleep-Inducing drugs		Name:	Thyroid Medication		Name:

Other Clinical Tests

Have you had any of the following performed since your injury:

X Rays: ☐ MRI: ☐ Bone Scan: ☐ CAT scan: ☐ Comments:_____

_____

Please list your current physicians: _____

What is your main goal in coming to physical therapy? _____

_____

Name: _____ **Signature:** _____ **Date:** _____

American Headache Institute

Head, Neck, & Facial Pain
Treatment Centers
Rochester Hills, MI
(248) 453-1543
americanheadacheinstitute.com

A Question before we begin treatment.

Our unique medical approach to relieving pain involves therapeutic methods and techniques designed to relieve stress on pain-sensitive tissues in your neck. In most cases, relieving stress in your neck can be accomplished in two ways;

1. Your therapist can DO THINGS (hands-on treatment techniques) to relieve your pain.
2. Your therapist can TEACH YOU THINGS (exercise, posture, education, etc.) to do to relieve your own pain.

Many times participation by both you & your therapist is required to achieve maximum pain relief. Patients often have different expectations of their treatment. Since our approach involves a "partnership" between patient & therapist, it would be very helpful to know the treatment partnership you would most prefer. Keep in mind that neck & headache problems are very recurrent and can often last a lifetime.

My preferred treatment partnership would be that,

(Please check only one)

☐	☐	☐	☐
my therapist do everything & teach me nothing to relieve my own pain.	my therapist do most everything & teach me a few things to relieve my own pain.	my therapist do fewer things & teach me many things to relieve my own pain.	my therapist do only what is needed & teach me everything possible to relieve my own pain.

Thank You

Your selection will help us create a pain relieving program that is best suited to your expectations.

American Headache Institute

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A Question before we begin treatment.

Patients often have different expectations of the results they might receive. It would be very helpful if you would select the percent (%) of pain relief you would be first, very satisfied with, and second, pleasantly surprised by.

Circle the % of pain relief you would be **"Very Satisfied"** with.

10-20% 25% 30-45% 50% 55-70% 75% 80-95% 100%

Circle the % of pain relief you would be **"Pleasantly Surprised"** by.

10-20% 25% 30-45% 50% 55-70% 75% 80-95% 100%

Thank You