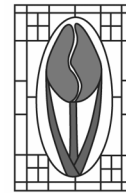


# Physical Therapy • Patient Information Sheet



**HOLLAND**  
Physical Therapy

**Willem Klokman, LPT,CBP**  
Licensed Physical Therapist  
Certified BodyTalk Practitioner

5401 Wrightsville Ave.  
Wilmington, NC 28403

phone **910.794.2900**

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Check One:  Male  Female Age: \_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

Cell Phone: (    ) \_\_\_\_\_ Email: \_\_\_\_\_

**Patient's Relationship to Insured:** (check one) Self Spouse Child Other \_\_\_\_\_

## Primary Insurance Information:

Policyholder Full Name \_\_\_\_\_ Check One: Male Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insurance Company: \_\_\_\_\_

Policyholders Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Group No. \_\_\_\_\_ Policy No. \_\_\_\_\_

## Secondary Insurance Information:

Policyholder Full Name \_\_\_\_\_ Check One: Male Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insurance Company: \_\_\_\_\_

Policyholders Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Group No. \_\_\_\_\_ Policy No. \_\_\_\_\_

Is your injury a result of an auto accident?  Yes  No Driver's License # \_\_\_\_\_ State \_\_\_\_\_

State in which accident occurred \_\_\_\_\_ Unable to work from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

If legal action is involved, please list Attorney Information: Telephone: (    ) \_\_\_\_\_

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

Attorney Address: \_\_\_\_\_

Is this a Worker's Compensation claim?  Yes  No Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation \_\_\_\_\_

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

Employer Address: \_\_\_\_\_

Unable to work: Beginning Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please list the information of the insurance we will send claims to: Insurance Claim Telephone: (    ) \_\_\_\_\_

Insurance Claim Name: \_\_\_\_\_

Insurance Claim Address: \_\_\_\_\_

## IMPORTANT RELEASE OF INFORMATION

I request that payment of insurance benefits be made on my behalf to Willem Klokman for any services furnished to me. I further understand that my signature authorizes release of medical information necessary for payment of any claim to Willem Klokman and I also understand that I am responsible for any co-pay, co-insurance, deductible or non-covered services. I authorize the release of my medical records to my referring and/or treating physician/counselor upon their request. I have read and understand the above statement.

Patient Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

# Physical Therapy • Patient Information Sheet

continued...



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## ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for all services rendered by Holland Physical Therapy. As a courtesy to me, the patient, Holland Physical Therapy will bill the insurance company listed on the Patient Information sheet. I understand that my account may be charged for any monies owed over 30 days from the date of service at the allowed percentage rate in accordance with North Carolina law. Additionally, should this account be sent to collections because of my failure to pay my bill as requested, I will be responsible for all costs & reasonable attorney's fee incurred with regards to this collection process. Furthermore, I agree to maintain a current home address & telephone number with Holland Physical Therapy at all times until my bill has been paid in full. I understand that Holland Physical Therapy requires 24 hour prior notification of cancellation of appointments except in emergency situations. Holland Physical Therapy may bill me personally for a missed appointment without prior notice at the rate of \$80.00 per missed appointment session. This charge will be my personal responsibility, and not that of my insurance carrier.

Patient Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

## ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

### FOR OFFICE USE • DO NOT FILL OUT BELOW THIS LINE

Name of Referring Physician: \_\_\_\_\_ NPI# \_\_\_\_\_

Diagnosis Codes: \_\_\_\_\_ Date Patient Last Seen: \_\_\_\_/\_\_\_\_/\_\_\_\_

Number of Visits: \_\_\_\_\_ Authorization # \_\_\_\_\_

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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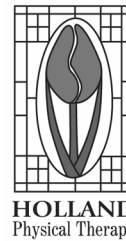
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# Physical Therapy • Subjective Form



**Willem Klokman, LPT,CBP**  
Licensed Physical Therapist  
Certified BodyTalk Practitioner

5401 Wrightsville Ave.  
Wilmington, NC 28403  
phone **910.794.2900**

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Referring Physician \_\_\_\_\_

Other Physician \_\_\_\_\_

Please complete this form so that we may provide the customized, safe and effective treatment for you.

Age: \_\_\_\_\_ Check One:  Right Handed  Left Handed Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Married  Single Children: \_\_\_\_\_ Are you presently working?  Yes  No

Employer: \_\_\_\_\_ Do you work full time or part time? \_\_\_\_\_

If not working, how long have you been unemployed? \_\_\_\_\_ Is your present injury/illness work related?  Yes  No

Describe your job activities: \_\_\_\_\_

Does your condition interfere with your routine daily activities?  Yes  No If yes, explain below:

What are your leisure or sports activities: \_\_\_\_\_

Are you presently taking any medications?  Yes  No If yes, list them below:

Have you ever been hospitalized, had surgery or fractured bones?  Yes  No If yes, list them below along with dates:

Please check any of the following conditions you have had or currently are experiencing:

- Diabetes  Respiratory Problems  Pacemaker  High Blood Pressure  
 Metal Implants or *other*: \_\_\_\_\_  Cancer \_\_\_\_\_  
 Dizzy Spells  Ulcers  Allergies (*please list*): \_\_\_\_\_  
 Other not listed: \_\_\_\_\_

Is there a chance that you may be pregnant currently?  Yes  No  Not Sure

Have you had physical therapy in the past?  Yes  No If yes, please describe:

What is the date of your next doctor's appointment? \_\_\_\_/\_\_\_\_/\_\_\_\_

How do you hope physical therapy or occupational therapy will assist you in managing your own health care?

What is the problem, as you see it, that brings you to physical therapy?

How long have you had this problem? \_\_\_\_  Weeks  Months  Years

How did this pain/problem begin?  Suddenly  Gradually  After Trauma Please describe below:

Is your condition getting:  Better  Worse  Same

Are there any cultural/religious issues or values/beliefs that I need to be made aware of that would affect your care?  No

If Yes, Please describe: \_\_\_\_\_

Is there anything else that you feel I ought to know about you? If yes, please describe below:

# Physical Therapy • Pain Evaluation



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**How intense is your pain?** Fill in one: **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

For Example: 1 = No Pain    5 = Moderate Pain    10 = Severe Pain

Is the pain:  Continuous  Off and On  Present Everyday  Present at the time

Other: \_\_\_\_\_

What percentage of your day is pain free? \_\_\_\_\_

When are you in pain? Check all that apply:  A.M.  P.M.  Midday  Evening

<p style="text-align: center;">On the illustration below, please shade in the areas of your body that cause you <u>PAIN</u>.</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p><b>FRONT</b></p> <p><b>Right</b>      <b>Left</b></p> </div> <div style="text-align: center;"> <p><b>BACK</b></p> <p><b>Left</b>      <b>Right</b></p> </div> </div>	<p style="text-align: center;">On the illustration below, please shade in the areas of your body where you experience <u>NUMBNESS, TINGLING</u> or <u>BURNING SENSATIONS</u>.</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p><b>FRONT</b></p> <p><b>Right</b>      <b>Left</b></p> </div> <div style="text-align: center;"> <p><b>BACK</b></p> <p><b>Left</b>      <b>Right</b></p> </div> </div>
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*Check all boxes that apply to each question below:*

**What position, movements or activities make your pain worse?** Lying on my:  Stomach  Back  Left Side  Right Side  
 Sitting  Car Riding  Getting Up from a Chair  Standing  Walking  Exercise  Other \_\_\_\_\_

**What position, movements or activities make your pain better?** Lying on my:  Stomach  Back  Left Side  Right Side  
 Sitting  Car Riding  Getting Up from a Chair  Standing  Walking  Exercise  Other \_\_\_\_\_

**Does the pain increase with?**  Coughing  Swallowing  Breathing  Sneezing

**Does the pain wake you at night?**  No  Yes, how often? \_\_\_\_\_

**What position do you sleep in mainly at night?**  Stomach  Back  Right Side  Left Side  Other \_\_\_\_\_

**Has there been any change to your patterns relating to:**  Bowel Movements  Bladder

Patient Signature \_\_\_\_\_ Date Signed \_\_\_\_/\_\_\_\_/\_\_\_\_

# Physical Therapy • Difficulty Baseline



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**HOLLAND**  
 Physical Therapy

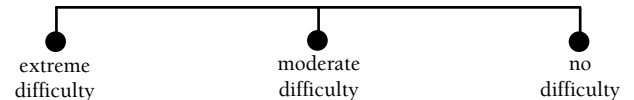
phone **910.794.2900**

## INSTRUCTIONS:

Please fill in the circle that best describes your level of difficulty of the activities listed.

ACTIVITIES	Able to do without any difficulty.	Able to do with little difficulty.	Able to do with moderate difficulty.	Able to do with much difficulty.	Unable to do.	Not Applicable
1. Lying Flat	①	②	③	④	⑤	⑨
2. Rolling Over	①	②	③	④	⑤	⑨
3. Moving: Lying to Sitting	①	②	③	④	⑤	⑨
4. Sitting	①	②	③	④	⑤	⑨
5. Squatting	①	②	③	④	⑤	⑨
6. Bending/Stooping	①	②	③	④	⑤	⑨
7. Balancing	①	②	③	④	⑤	⑨
8. Kneeling	①	②	③	④	⑤	⑨
9. Walking: Short Distance	①	②	③	④	⑤	⑨
10. Walking: Long Distance	①	②	③	④	⑤	⑨
11. Walking: Outdoors	①	②	③	④	⑤	⑨
12. Climbing Stairs	①	②	③	④	⑤	⑨
13. Hopping	①	②	③	④	⑤	⑨
14. Jumping	①	②	③	④	⑤	⑨
15. Running	①	②	③	④	⑤	⑨
16. Pushing	①	②	③	④	⑤	⑨
17. Pulling	①	②	③	④	⑤	⑨
18. Reaching	①	②	③	④	⑤	⑨
19. Grasping	①	②	③	④	⑤	⑨
20. Lifting	①	②	③	④	⑤	⑨
21. Carrying	①	②	③	④	⑤	⑨

22. Thinking of all of the activities that you would like to do, please mark an "X" at the point on the line that best describes your overall level of difficulty with your activities today: *Put X on the line here --->*



23. From the list above, pick three numbers that correspond to the activities you would most like to be able to do without any difficulty. (For example: 1. 12 2. 8 3. 13)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ Your Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_