

Patient Intake Sheet

Patient Name: Last: _____ First: _____ MI: _____

Address: _____ City: _____ State/Zip: _____

Primary PH # _____ Secondary PH # _____

Birth Date: ____/____/____ Sex: M F Other Social Security # ____ - ____ - ____

Emergency Contact: _____ PH # _____

Injury site/Diagnosis: _____

Referring Physician: _____ PCP: _____

Insurance Information

____ Worker's Comp ____ Auto

Primary Ins Name: _____ Policy/Claim #: _____ Group #: _____

Secondary Ins Name: _____ Policy/Claim #: _____ Group #: _____

Received PT or Speech services this calendar year? YES / NO **If yes, how many visits: _____

Receiving services from the VNA or Home Health? YES / NO

Is this part of a Worker's Compensation Claim? YES / NO

Employer Name: _____ Employer Address: _____

HIPAA CONSENT

- I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews
- I have been informed that I may review the practice/clinic's Notice of Privacy Practice (for a more complete description of uses and disclosures) before signing this consent
- I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic
- I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction(s), they must follow the restriction(s)
- I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed

May we discuss your medical condition with any members of your family? YES / NO

If Yes, please name: _____

May we leave a message on your phone with medical information? YES / NO

OFFICE POLICIES

CANCELLATION / NO SHOW POLICY: We will be unable to treat patients who either fail to keep appointments (No show) or frequently cancel appointments. Failure to provide 24 hours' notice of cancellations may constitute a \$25.00 charge. A no show constitutes an automatic \$25.00 charge.

ASSIGNMENT OF INSURANCE/RESPONSIBILITY OF CHARGES INCURRED; the undersigned authorizes direct payment to Falmouth Physical Therapy of any insurance benefits otherwise payable to or on behalf of the patient for these outpatient services. It is understood by the undersigned that he/she is financially responsible for charges not covered or partially covered by insurance. Any claims not paid by insurance within 90 days of the date of service become the patient's responsibility. Falmouth Physical Therapy will not wait for court settlements to be reached to have bills paid, unless special arrangements are made with this office prior to initiation of treatment. In cases where insurance does not cover physical therapy, payment plans can be arranged.

PATIENTS ARE RESPONSIBLE FOR:

- Scheduling all physical therapy appointments well in advance
- Obtaining the required referrals from Primary Care Physicians
- Co-payments, which are due at the time of service

MEDICARE B PATIENTS: Medicare B covers physical therapy at 80%. If you wish us to bill your supplemental insurance, all insurance information must be provided at the time of your initial visit.

PERSONAL VALUABLES: Falmouth Physical Therapy does not maintain a safe for money or valuables. Falmouth Physical Therapy shall not be liable for loss of appliances, garments, or other articles of unusual value, or damage to any other physical property.

By signing, I acknowledge that I have provided accurate insurance information, have reviewed a copy of the HIPAA consent disclosure, and agree to Falmouth Physical Therapy's policies.

Patient / Guardian Signature: _____

Printed Name: _____

Date: _____

Family History

Please list if your father, mother, siblings, aunt/uncle, or grandparent has had any of the following conditions:

Arthritis: _____ Cancer: _____

Diabetes: _____ Heart Disease: _____

Hypertension: _____ Osteoporosis: _____

Psychological: _____ Stroke: _____

Other: _____

Patient Signature: _____

Date: _____

Client History Information

****Please fill out to the best of your ability and focus on what is pertinent to your visit with us today****

General Health Status

Please rate your health: Excellent Good Fair Poor
Exercise: None Moderate Daily Heavy Athlete
Health Habits: Alcohol Water Coffee/Caffeine Stress
Any Major Life Changes in the Past Year? (eg. new baby, job change, death in family) Yes No

If yes, please describe: _____

Medical/Surgical History Please check if you have ever had:

- | | | |
|--------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Infectious Disease (TB, Hepatitis) | <input type="checkbox"/> Repeated Infections |
| <input type="checkbox"/> Circulation/Vascular Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Low Blood Sugar/Hypoglycemia | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Developmental/Growth Issues | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes/High Blood Sugar | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers/Stomach Problems |

Other: _____

Broken Bones/Fractures (include dates)
_____/_____/_____
_____/_____/_____

Surgeries (include dates)
_____/_____/_____
_____/_____/_____

Allergies: _____

Supplements/Herbs: _____

Medications: (Dosage and Frequency): _____

If female, is there a change you may be pregnant? YES / NO

Do you have any metal implants or a pacemaker? YES / NO

Insurance requires the following information for ALL PATIENTS

Height* _____ Weight* _____

**Have you fallen in the past year? YES / NO

**If you have fallen in the past year, did you sustain an injury from that fall? YES / NO

**Do you currently use any type of tobacco product? YES / NO

Over the past 2 weeks, how often have you been bothered by the following problems:

Little interest or pleasure in doing things: Not at all Several days More than half Nearly every day

Feeling down, depressed, or hopeless: Not at all Several days More than half Nearly every day

Employment/Recreation

Are you: A Student Employed Unemployed A Homemaker Retired

Hobbies/Sports: _____

Current Employment: Job Title _____ Part-time Full-time

Work Activity: None Sitting Standing Light Labor Heavy Labor

Out of Work Due to Injury? No Yes, please describe: _____

Work Restriction: No Yes, please describe: _____

Current Condition/Chief Complaint

Reason for Visit: _____

Is this condition: A New Problem A Chronic Problem Unknown

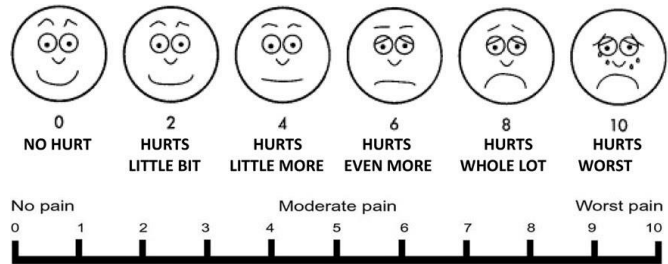
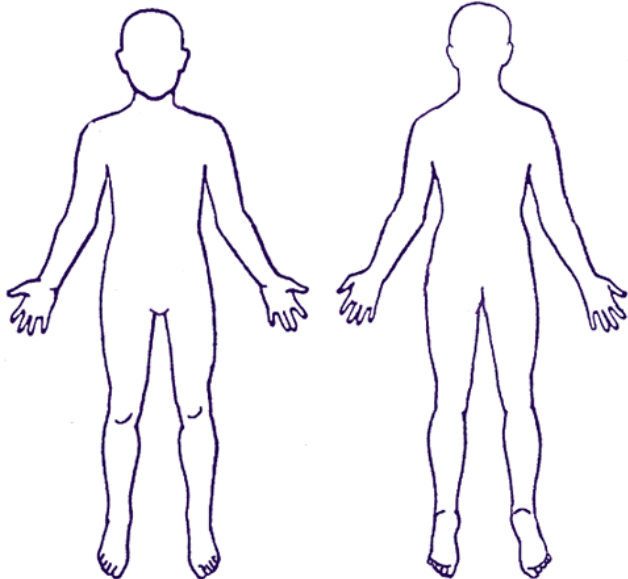
When did symptoms appear? _____ Is it getting worse? Yes No Unknown

What makes the problem(s) better? _____

What makes the problem(s) worse? _____

What are your goals for physical therapy? _____

Please circle the location of your pain or where you may be having difficulty functioning and circle your level of pain on the right.



Are you seeing anyone else for the problem(s)? *Please check all that apply*

- Acupuncturist Cardiologist Chiropractor Dentist
- Family Practitioner Internist Massage Therapist Neurologist
- OBGYN OT Orthopedist Osteopath
- Pediatrician Podiatrist Primary Care Dr. Rheumatologist
- Other: _____

Is your problem affecting your daily activities? *Please check all that apply*

- Bed Mobility Walking Driving Recreation
- Shopping Household Care Dependent Care Self Care (bathing, dressing, etc.)

Patient Signature: _____

Date: _____