Please bring this completed form and your insurance card to your first visit.

Falmouth Physical Therapy

Patient Name_____
Patient ID #_____

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

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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/RESPONSBILITY 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: _____

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Falmouth Physical Therapy

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Patient ID #_____

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:

___Arthritis	___Heart Problems	___Muscular Dystrophy
___Asthma	___High Blood Pressure	___Osteoporosis
___Blood Disorders	___High Cholesterol	___ Parkinson's
___Cancer	___Infectious Disease (TB, Hepatitis)	___Repeated Infections
___Circulation/Vascular Problems	___Kidney Problems	___Seizures/Epilepsy
___Depression	___Low Blood Sugar/Hypoglycemia	___Skin Disease
___Developmental/Growth Issues	___Lung Problems	___Stroke
___Diabetes/High Blood Sugar	___Migraine Headaches	___Thyroid Problems
___Head Injury	___Multiple Sclerosis	___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

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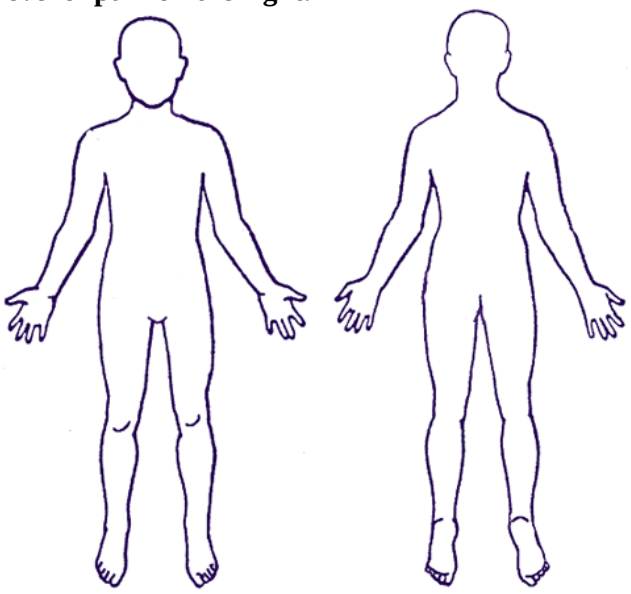
Employment/Recreation

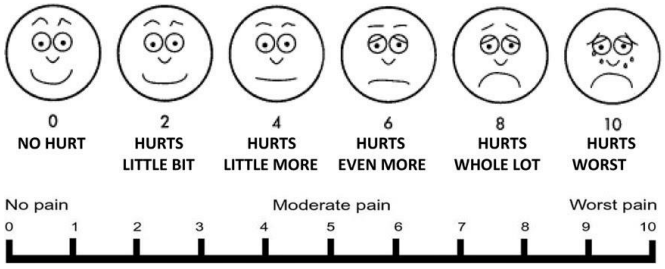
Are you: ___A Student ___Employed ___Unemployed ___A Homemaker ___Retired
Hobbies/Sports: _____
Current Employment: Job Title _____ ____Part-time ____Full-time
Work Activity: ___None ___Sitting ___Standing ___Light Labor ___Heavy Labor
Out of Work Due to Injury? ___No ___Yes, please describe: _____
Work 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: _____