FALMOUTH PHYSICAL THERAPY
Patient Intake Sheet

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

Address: _____ City: _____ State/Zip: _____

Phone # _____ Secondary Phone # _____

Birth Date: _____/_____/_____ Sex (circle one): M F

Emergency Contact: _____ Phone # _____

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

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: _____

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 $35.00 charge. A no show constitutes an automatic $35.00 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

Patient Signature:_____ Date:_____

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: _____ Date: _____

CLIENT HISTORY

Please rate your health: ___Excellent ___Good ___Fair ___Poor
Exercise: ___None ___Moderate ___Daily ___Heavy
Health Habits: ___Alcohol ___Water ___Coffee/Caffeine ___Stress ___Tobacco
Any Major Life Changes in the Past Year? (eg. new baby, job change, death in family) ___Yes ___No
If yes, please describe: _____

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): _____
_____

FALMOUTH PHYSICAL THERAPY
Patient Intake Sheet

If female, is there a change you may be pregnant? YES / NO
Do you have any metal implants or a pacemaker? YES / NO If yes, explain: _____

Insurance requires the following screening 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 feel happy most of the time? YES / NO
- Have you dropped many of your activities and interests? YES / NO
- Have you relied on people for bathing, dressing, shopping, banking, or meals? YES / NO
- Have you been upset because someone talked to you in a way that made you feel shamed or threatened? YES / NO
- Has anyone made you afraid, touched you in ways that you didn't want, or hurt you physically? YES / NO

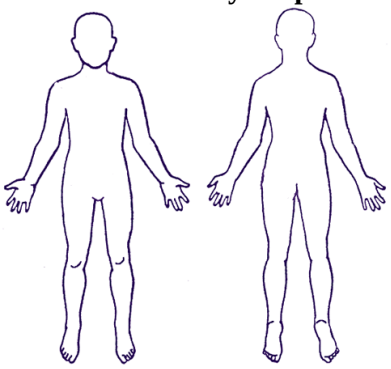
EMPLOYMENT/RECREATION

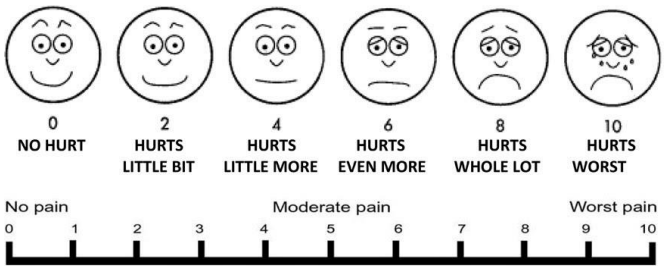
Are you: ___A Student ___Employed ___Unemployed ___A Homemaker ___Retired
Hobbies/Sports: _____
Current Employment: Job Title _____ ____Part-time ____Full-time
Work Activity: ___None ___Sitting ___Standing ___Light Labor ___Heavy Labor
Out of Work Due to Injury? ___No ___Yes, please describe: _____
Work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

CURRENT STATUS

Reason for Visit: _____
Is this condition: ___New Problem ___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 and circle your level of pain





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:_____