

# 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: \_\_\_\_\_

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### **Insurance Information**

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**

**Is this part of a Motor Vehicle Accident Claim? YES / NO**

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### **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 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: \_\_\_\_\_

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**CLIENT HISTORY**

Medial history – please check if you have/have had:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Alzheimer's/Dementia/Memory Issues        | <input type="checkbox"/> Cardiovascular Disease/Heart Issues |   |
| <input type="checkbox"/> Stroke/TIA                                | <input type="checkbox"/> Infections                          | <input type="checkbox"/> Diabetes (Type I / Type II) circle one |
| <input type="checkbox"/> Fibromyalgia                              | <input type="checkbox"/> High Blood Pressure                 | <input type="checkbox"/> Osteoporosis                           |
| <input type="checkbox"/> Cancer – please write type and year _____ |  |   |
| <input type="checkbox"/> Compromised Immune System                 | <input type="checkbox"/> Lupus                               | <input type="checkbox"/> Osteoarthritis                         |
| <input type="checkbox"/> Parkinson's                               | <input type="checkbox"/> Rheumatoid Arthritis                | <input type="checkbox"/> Traumatic Brain Injury / Concussion    |
| <input type="checkbox"/> Multiple Sclerosis                        | <input type="checkbox"/> Difficulty Breathing / Lung Issues  |   |

If yes, please describe: \_\_\_\_\_

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

Medications: (dosage and frequency): \_\_\_\_\_

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

Do you have any metal implants or a pacemaker? YES / NO If yes, explain: \_\_\_\_\_

Broken Bones/Fractures (include dates): \_\_\_\_\_

Surgeries (include dates): \_\_\_\_\_

Allergies: \_\_\_\_\_

**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
- Do you live alone? YES / NO
- Do you live on one floor? YES / NO

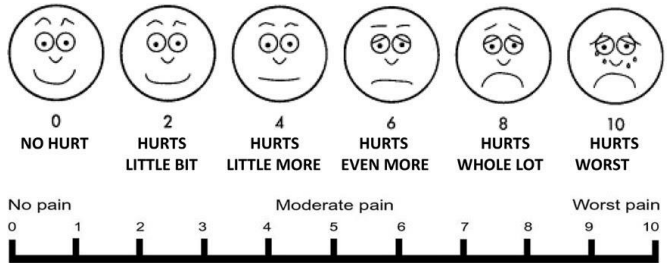
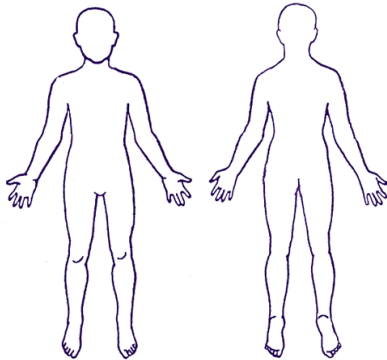
**EMPLOYMENT/RECREATION**

Are you: \_\_\_A Student \_\_\_Working \_\_\_Homemaker \_\_\_Retired  
If working, employment: Job Title \_\_\_\_\_ Part-time \_\_\_Full-time  
Hobbies/Sports: \_\_\_\_\_

**CURRENT STATUS**

Reason for Visit: \_\_\_\_\_  
Date of Injury (approximate): \_\_\_\_\_  
Date of Surgery (if applicable): \_\_\_\_\_  
Is this condition: \_\_\_New \_\_\_Chronic Is it getting worse? \_\_\_Yes \_\_\_No  
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.)

**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: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_