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

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

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: _____

CLIENT HISTORY

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

___Alzheimer's/Dementia/Memory Issues ___Cardiovascular Disease/Heart Issues
___Stroke/TIA ___Infections ___Diabetes (Type I / Type II) circle one
___Fibromyalgia ___High Blood Pressure ___Osteoporosis
___Cancer – please write type and year _____
___Compromised Immune System ___Lupus ___Osteoarthritis
___ Parkinson's ___Rheumatoid Arthritis ___Traumatic Brain Injury / Concussion
___Multiple Sclerosis ___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
- Do you use any form of tobacco? YES / NO

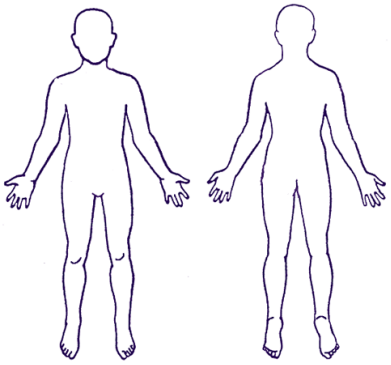
EMPLOYMENT/RECREATION

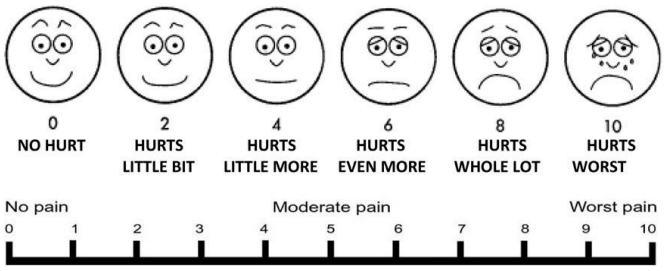
Are you: ___A Student ___Working ___Homemaker ___Retired
If working, employment: Job Title _____ ____Part-time ____Full-time
Hobbies/Sports: _____

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
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:_____