Patient Intake Form

Patient's Name: ____ Date: _________________________

Mailing Addres________________________City______________State_____________________Zip_____________

Physical Addres_______________________City______________State_____________________Zip_____________

Home Phone ___________________ Work phone _____________________ Cell Phone ______________________

Contact Preference: □Home □Work □ Cell □ E-mail E-mail Address_____________________________________

SSN ___________________________ Birth Date __________________ Sex: □ Female □ Male

Marital Status: □ Single □ Married □ Divorced □ Widowed Spouse/Partner's Name _________________________

Employer: ____ Primary Physician _____________________________

Emergency Contact ___________________________________ Relationship ________________________________

Emergency Contact Phone # ____

Please tell us how you learned of our service:

□ I was a **Former Patient** □ Found us on the **Internet**

□ **Family/Friend/Co-worker** recommendation □ **Doctor** recommendation □ **Radio** advertisement

□ **Phone book** □ **Publication/Newspaper**; what Publication: ___________________

□ **Clinic Sign** □ Saw you at an **event**: what Event: ______________________

Please be at the clinic and ready to begin your therapy at the scheduled time.

- **A scheduled appointment MUST BE CANCELED AT LEAST 24 HOURS IN ADVANCE, or a fee will be charged for that appointment.**
- **Failure to show up for an appointment ("NO SHOW") without notifying us will result in a fee being charged for that appointment. Furthermore, 2 no-shows will result in the cancellation of all remaining scheduled appointments.**
- **At week's end, ALL PATIENTS, regardless of insurance/third party payor, will be charged a $25 CANCELLATION FEE for each late, late-canceled, or no-show appointment. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR.**
- **No cancellation fee will be charged if the missed appointment is made up within the same week it was scheduled on a day that you do not have another appointment scheduled.**
- **All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.** (Initials)_________

Consent for Physical Therapy Treatment

I understand that I am a patient of Dynamic Physical Therapy and their independent physical therapy practitioners. My care is the exclusive responsibility of the practitioners of Dynamic Physical Therapy.

Cooperation with treatment: In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment: The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increase strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physical therapist, as well as my physician or primary care provider.

Payment: I understand that I am responsible for any charges not covered by insurance.

Attendance: I have read, understand and consent to the Attendance/Cancel/No Show Policy. Late cancelations and No Show to appointments will have a $25 fee charged to the patient. Patients who have more than one No Show will not be schedule again.

I have read the above information and I consent to physical therapy evaluation and treatment, payment and attendance policies.

________________________________ ___________________________

Patient or Parent/Guardian Signature Date

<u>**Patient Questionnaire/Health History**</u>

Patient Name: ____ **Date:** ________________________________

To ensure your receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you!

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of accident ___________ □ Auto □ Work □ Other State in which injury occurred ________

Claim number ____________________Insurance company (worker's comp or auto PIP) _______________________

Address ________________________________Claims Adjuster ___________________ Phone # ______________

Referring Provider:__________________________

History of Present Condition:

What are your current symptoms? ____________________

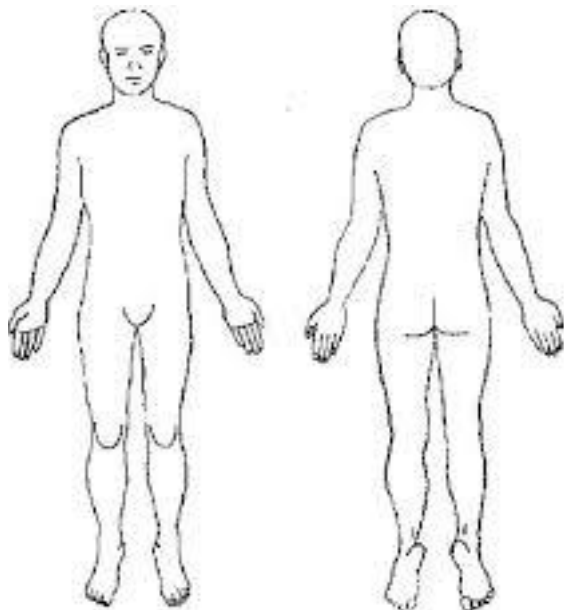
____

____

____

____

Please indicate the area of **pain** or **abnormal** sensation on the body chart below (shade in the appropriate area)



When did your symptoms begin? ___________________

Was onset gradual or sudden : □ Gradual □ Sudden

Since onset are symptoms getting:
□ better □ worse □ not changing

Have you had similar symptoms in the past? YES NO

Have you had more than one episode? YES NO

Which of the following **best describes** how your injury occurred? (If your condition is post-surgical please indicate as per original injury)

□ Lifting
□ MVA (car accident)
□ A fall
□ Overuse (cumulative trauma)
□ During recreation/sports
□ Trauma
□ Blow to the face
□ Throwing
□ An incident at work
□ Degenerative process
□ Unknown
□ Other

Nature of pain/symptoms (check all that apply)

□ sharp □ aching □ constant
□ dull □ periodic □ other ______________
□ throbbing □ occasional ____________________

Throughout the day do your symptoms: (check one)

□ increase □ decrease □ stay the same

Does the pain wake you at night? YES NO

Since onset of your current symptoms have you had:

□ any difficulty with control of bowel or bladder function
□ fever/chills
□ any numbness in the genital or anal area
□ numbness in arms or legs
□ any dizziness or fainting attacks
□ weakness
□ unexplained weight change
□ night pain/sweats
□ malaise (vague feeling of bodily discomfort)
□ problems with vision/hearing
□ none of these

Have you had any previous treatment for this condition?
____

Have you had any imaging done? (x-rays, MRI, CT scan)
____

What **aggravates** your symptoms? (check all that apply)

- □ sitting
- □ going to/rising from sitting
- □ lying down
- □ walking
- □ up/down stairs
- □ reaching overhead
- □ reaching in front of body
- □ reaching behind back
- □ reaching across body
- □ talking, chewing, yawning
- □ recreational sports including
- □ repetitive activities
- □ household activities
- □ standing
- □ squatting
- □ sleeping
- □ coughing/sneezing
- □ taking a deep breath
- □ looking up overhead
- □ swallowing
- □ stress
- □ sustained bending
- □ other: ______________________________________

What **relieves** your symptoms? (check all that apply)

- □ sitting
- □ heat
- □ cold
- □ stretching
- □ wearing a splint/orthosis
- □ rest
- □ standing
- □ walking
- □ exercise
- □ lying down
- □ massage
- □ medication
- □ nothing
- □ other ______________ ____________________

Medication

Please list any prescription medications you are currently taking (pain pills, injections and/or skin patches, etc):
____
____
____
____
____

General Health

How would you rate your general health?
□ Excellent □ Good □ Average □ Poor

Do you exercise outside of normal daily activity?
□ 5+ days/wk □ 1-2 days/wk □ none
□ 3-4 days/wk □ occasionally

Exercise, Sports/Recreation consists of: _____________
____
____
____

Past Medical History

Have you ever been diagnosed with any of the following conditions? (check all that apply)

- □ Cancer (type) ____________
- □ Depression
- □ Stroke
- □ Kidney problems
- □ Thyroid problems
- □ Diabetes
- □ Multiple Sclerosis
- □ Head injury
- □ Stomach problems
- □ Parkinson's disease
- □ Infectious diseases
- □ Arthritis
- □ Heart problems
- □ High blood pressure
- □ Lung problems
- □ Blood disorders
- □ Epilepsy/seizures
- □ Allergies
- □ Rheumatoid arthritis
- □ Osteoporosis
- □ Broken bones
- □ Circulation/vascular problems
- □ Other _____________

Do you smoke? If yes, how much? __________________
____

Are you currently pregnant? ________________________

Work History

Occupation: _____________________________________

Physical Activities at work (check all that apply)

- □ sitting
- □ standing
- □ phone use
- □ repetitive lifting
- □ heavy lifting
- □ computer use
- □ heavy equipment operation
- □ driving
- □ other __________________

Are you currently receiving or seeking disability for this condition?

YES NO

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

YES NO