CREEKSIDE PHYSICAL THERAPY PATIENT INTAKE INFORMATION

PATIENT INFORMATION

Last Name:	First Name:	MI:	Date: / /
Mailing Address:		City:	
State:	Zip:	Email Address:	
Birth Date: / /	Age:	☐ Male ☐ Female	S.S.# - -
Please select preferred contact method for reminders: ☐ voicemail ☐ text message ☐ e-mail			
Home Phone:	Cell Phone:	Work Phone:	
Employer:	Occupation:		
Guarantor (responsible for Payment) Name:	Address:	Home/Work Phone:	

IN CASE OF EMERGENCY

Name:	Phone:	Relationship to Patient:

INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:	
Subscriber's Name (if different):	DOB: / /
ID Number:	Group/policy Number:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	
Secondary Insurance Name:	
Subscriber's Name (if different):	DOB: / /
ID Number:	Group/policy Number:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE PRIVATE INSURANCE INFORMATION ALSO)

Insurance Name: ☐ Auto:	☐ Workers Comp Company:	
Adjuster/Claim Manger:	Phone Number/Ext.:	
Address:	City:	State/Zip:
Claim Number:	Accident Date:	Cause:
Employer when injured:	Address of Employer:	
Body Part covered on claim:	PIP Benefit Remaining:	

ATTORNEY INFORMATION

Name:	Law Firm:	Phone:
Address:	City:	State/Zip:

CANCELLATION/NO SHOW POLICY

We are sincerely concerned with helping you meet your goals of therapy. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapy team to progress your treatment program which will result in quicker recovery and better outcomes.

We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, please give us as much notice as possible so we can reschedule the time for another patient and find another time for your appointment. Canceling an appointment with short notice or not showing up for an appointment takes up clinic time that could benefit another person.

Please review the following policy, sign below and return to the front office staff. Should you have any further questions, please consult with your therapist.

Thank you for your cooperation.

If you cannot make it to your appointment, please contact our office at least **24 hours** in advance to cancel your appointment.

First late cancellation fee will be $25, and $50 thereafter.

If you miss 3 appointments without proper notice, all future appointments will be canceled. You will only be allowed to schedule ***one*** appointment at a time until fees are paid in full. Once fees are paid, you will be able to schedule one appointment in advance.

No fees will be waived. Special circumstances will be handled on a case-by-case basis. If you intend to dispute the charge, you should speak with your therapist at the next appointment.

Patient Name: _____

Signature: _____ **Date:** _____

Authorization for Treatment: I voluntarily consent to physical therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatments to be provided in this healthcare facility. I authorize Creekside Physical Therapy to provide such treatment. **INITIALS**_____

PAYMENT AUTHORIZATION: I request that payment be made on my behalf to Creekside Physical Therapy for services furnished to me by Creekside Physical Therapy. I authorize Creekside Physical Therapy to release to the Centers for Medicare & Medicaid Services and its agents, any state Medicaid agency, and any other third party payor all medical or other information that is needed to determine the benefits payable for health services. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance including any reasonable collection fees required to collect delinquent accounts. **MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION AND I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR PHYSICAL THERAPY SERVICES RENDERED.** **INITIALS**_____

RECORD RELEASE: I hereby authorize Creekside Physical Therapy to release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care. **INITIALS**_____

Please also release medical information regarding my physical therapy care to the following individual(s) (i.e., family members, coaches, trainers, etc.). It is not necessary to list physicians or insurance companies here.

Name	**Relationship**	**Phone Number**

HIPPA PRIVACY POLICY: I have been provided a copy of the HIPPA Privacy Policy for review and know that if I would like a copy of it to keep, I have requested one. **INITIALS**_____

CANCEL/NO SHOW POLICY: I have read and understand Creekside Physical Therapy's Cancel/No Show Policy and know that if I would like a copy of it to keep, I have requested one. **INITIALS**_____

As part of working with my insurance carrier, I recognize that Creekside Physical Therapy may be provided with information about my insurance coverage and that on occasion Creekside Physical Therapy may share some of this information with me. However, I understand and acknowledge that Creekside Physical Therapy is not responsible for the accuracy of any insurance coverage information shared with me, and that I am solely responsible for reviewing my insurance plan documents and/or working with my insurance carrier to determine the scope and details of any available insurance coverage. By signing below, I agree that I am responsible for the bill for any services rendered for myself or the patient for whom I am signing.

Patients printed name: _____

Date: _____ _____

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor

If signed by Patient representative or Parent/Legal Guardian, indicate relationship to Patient: _____

CREEKSIDE PHYSICAL THERAPY

Patient Name:	Date of Birth:	Date Completed:
Allergies/Adverse effects to medications:		

1. Complete the patient information section above.
2. In order to provide optimal care it is important for us to maintain an up-to-date list of all your medications (over the counter, prescription, herbal, or natural medication, vitamins and minerals).
3. To help us obtain this information, please fill out the chart below.

Name of medication (brand or generic)	Dosage	Reason for Taking	Frequency (daily, bid)	Route (oral, injection, etc.)
Prescriptions				
Over the Counter/Supplements				

Patient Health Questionnaire

Name: _____ Date: ___/____/_____ Age: _____ Occupation: _____

Past Medical History

Please mark each of the following that you have been told you have or had:

- ☐ Allergies: _____
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease: Type: _____
- ☐ Blood Clots
- ☐ Cancer: Type: _____
- ☐ Cardiac Conditions
- ☐ Cardiac Pacemaker
- ☐ Chemical Dependency
- ☐ Currently Pregnant
- ☐ Depression
- ☐ Diabetes: Type: _____
- ☐ Dizzy Spells
- ☐ Emphysema/Bronchitis
- ☐ Fractures
- ☐ Gallbladder Problems
- ☐ Gout
- ☐ Hearing Impairments
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Incontinence
- ☐ Kidney Problems
- ☐ Metal Implants
- ☐ Multiple Sclerosis
- ☐ Muscular Disease
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Peripheral Vascular Disease
- ☐ Polio/Post-polio
- ☐ Prosthesis/Implants
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Stroke/TBI
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vision Problems
- ☐ Pacemaker
- ☐ Spinal Cord Stimulator
- ☐ Stomach Ulcers
- ☐ NONE
- ☐ Other: _____

In the past 3 months have you experienced any of the following?

- ☐ A change in your health
- ☐ Unexplained weight changes
- ☐ Numbness/Tingling
- ☐ Fever/Chills/Sweats
- ☐ Ringing in Ears
- ☐ Hearing Loss
- ☐ Nausea/Vomiting
- ☐ Headaches
- ☐ Difficulty Swallowing
- ☐ Pain wakes me at night
- ☐ Chest Pains/Angina
- ☐ Change in Appetite
- ☐ Shortness of Breath
- ☐ Bowel or Bladder Disorders

Social History/Wellness

In general would you say your overall health right now is:

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

Do you smoke cigarettes? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

Do you drink coffee/caffeine drinks? ☐ YES ☐ NO

Leisure Activities/Regular Exercise: _____

History of Falls:
How many times have you fallen in the past 12 months? _____
Did your fall(s) result in injury? ☐ YES ☐ NO
Do you have difficulty with balance? ☐ YES ☐ NO

Past Surgical History: Type and Date:

_____
_____
_____
_____

Imaging: Body part and date
X-Rays: _____ Nerve Conduction Test: _____
MRI: _____ Other: _____
Bone Density Test: _____

Current Symptoms:
Primary Concern/Chief Complaint: _____

When did this first begin: _____/_____/_____

How did this problem begin? _____

Have you ever had this problem before? ☐ YES ☐ NO

Are your symptoms worse in: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

My pain/problem is getting: ☐ Better ☐ Staying the same ☐ Worse

How often do you experience your symptoms:
☐ Intermittently (0% - 25% of the day) ☐ Occasionally (26% - 50% of the day)
☐ Frequently (51% - 75% of the day) ☐ Constantly (76% - 100% of the day)

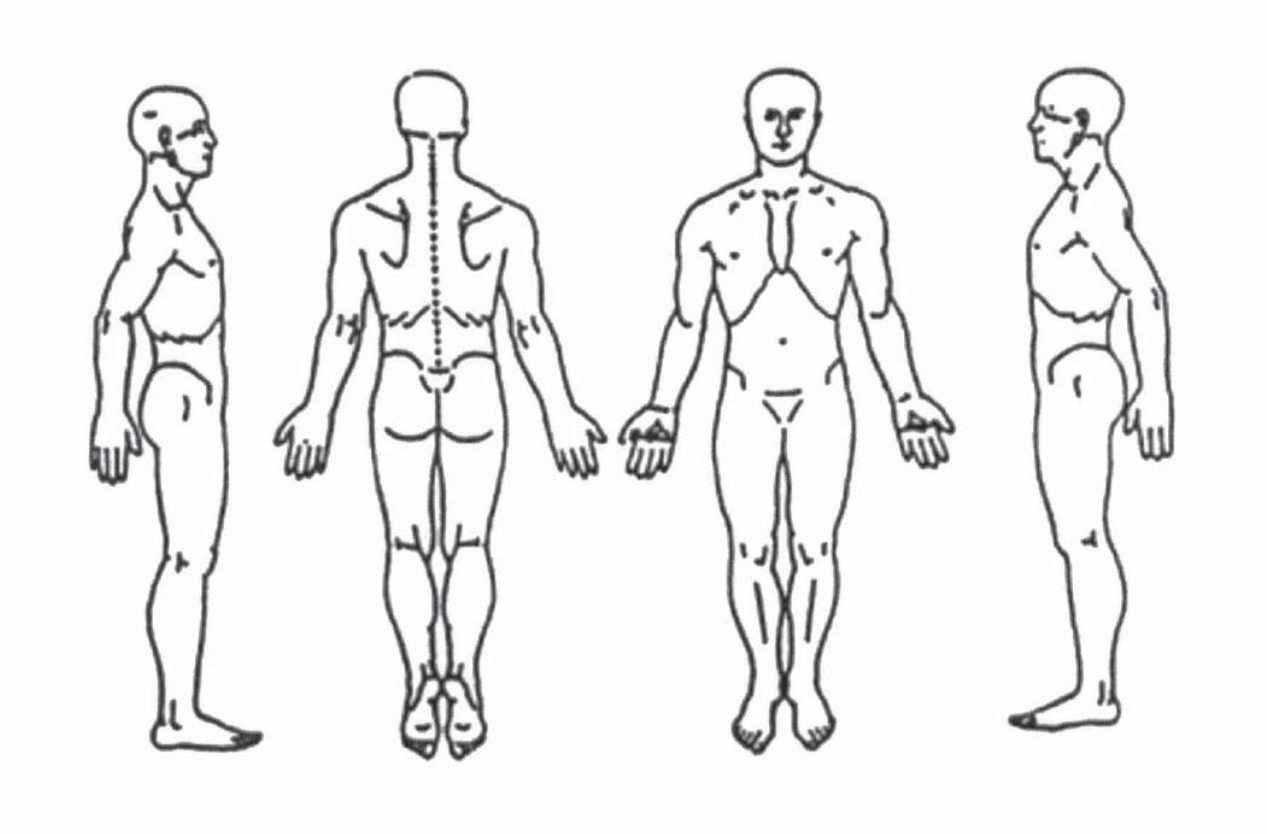
"I should not do physical activities which (might make my pain worse." Please rate your level of agreement with this statement below.

0	1	2	3	4	5	6
Completely Disagree			Unsure			Completely Agree

During the past month, have you often been bothered by feeling down, depressed, or hopelessness? ☐ YES ☐ NO

During the past month, have you often been bothered by little interest or pleasure in doing things? ☐ YES ☐ NO

Please indicate your current symptoms on the diagram below:
Sharp/Shooting: ////
Dull Ache: ZZZZ
Numb/Tingling: OOOO
Burning: XXXX



What describes the nature of your pain?

- ☐ Sharp
- ☐ Dull Ache
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

Rank your pain from scale of 0-10 (10 is unbearable) in past 4 weeks:

Highest: _____ Lowest: _____ Average: _____

What makes your pain better? _____

What makes your pain worse? _____