

CREEKSIDE PHYSICAL THERAPY PATIENT INTAKE INFORMATION

PATIENT INFORMATION					
Last Name:	First Name:	MI:	Date: / /		
Mailing Address:		City:			
State:	Zip:	Email Address:			
Birth Date: / /	Age:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	S.S.# - -	
Please select ONE preferred contact method for reminders: <input type="checkbox"/> voicemail <input type="checkbox"/> text message <input type="checkbox"/> e-mail					
Home Phone:		Cell Phone:		Work Phone:	
Employer:		Occupation:			
Guarantor (Responsible for Payment) Name:		Address:		Home/Work Phone:	
Birth Date: / /					
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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Secondary Insurance Name:					
Subscriber's Name (if different):			DOB: / /		
ID Number:			Group/Policy Number:		
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE PRIVATE INSURANCE INFORMATION ALSO)					
Insurance Name: <input type="checkbox"/> Auto:			<input type="checkbox"/> Workers Comp Company:		
Adjuster/Claim Manager:			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 NO SHOW fee will be \$25, and \$50 thereafter.

If you miss 3 appointments without proper notice, all future appointments will be canceled.

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.

Patient's 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: _____

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 _____

Patient's 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: _____

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:

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

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

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

SOCIAL HISTORY/WELLNESS

- 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: _____

MRI: _____

Bone Density Test: _____

Nerve Conduction Test: _____

Other: _____

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: 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)

Using the appropriate symbol, please indicate your current symptoms on the diagram below:

Sharp/Shooting

////

Dull Ache

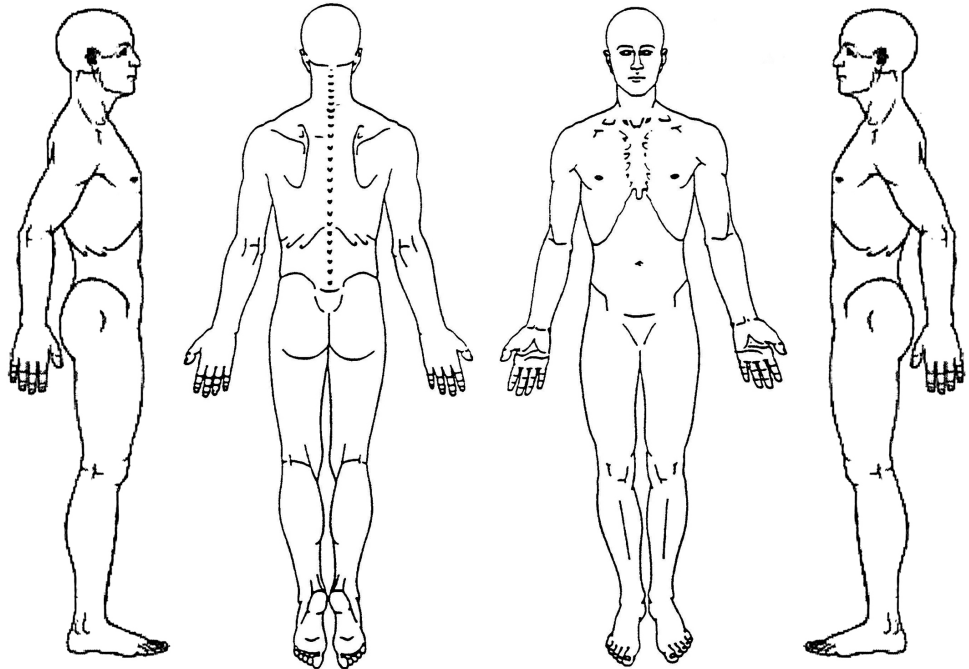
ZZZZ

Numb/Tingling

OOOO

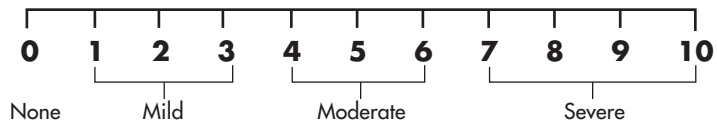
Burning

XXXX



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

Highest: ____ Lowest: ____ Today: ____



What makes your pain better? _____

What makes your pain worse? _____