Patient Intake Form

Patient Information:

Last name: _____ First Name: _____ Sex: _____

Date of Birth: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Preferred Contact Phone #: ( ) _____ Cell/Home/Work (circle one)

Email: _____

Physician's Name: _____ Diagnosis: _____

Injury: Work or Auto related? Yes No (circle one) If yes, which: _____

Allergies or Medical Precautions: _____

Emergency Contact: _____ Phone #: ( ) _____

Insurance Information:

Insurance Co. Name: _____ Policy #: _____

Patient Responsibility: _____

We will take a copy of your payment method and place in your file

I hereby accept responsibility for the cost of this examination or treatment in the event that the insurance company denies this claim.

***Patient Signature**:* _____

Patient History

What is your Chief Complaint? _____

_____

Has this problem affected your daily life or routine? Briefly describe in what ways _____

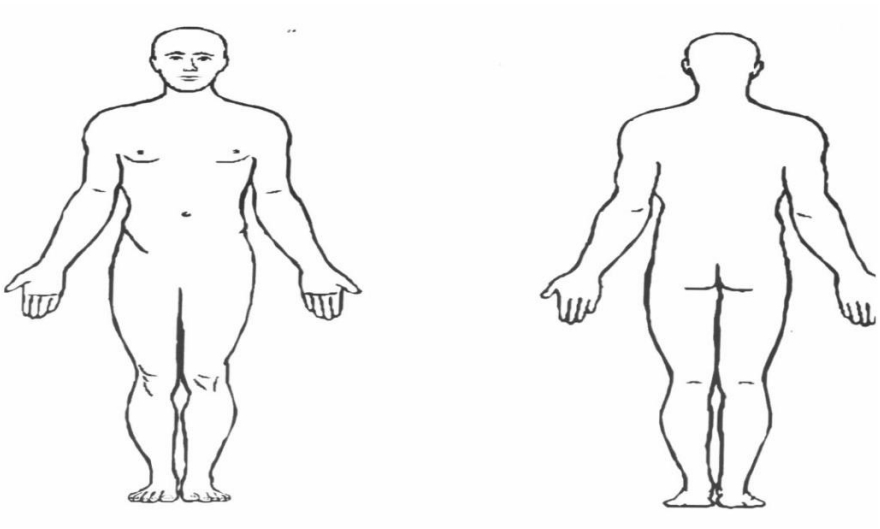
_____

When and how did this problem begin: _____

_____

Where is your problem? Indicate on the body chart. Represent symptoms with the following characters:

Pain xxx *Numbness ooo* *Tingling zzz*



Indicate the nature of your pain & symptoms: ____ Sharp ____ Dull ____ Piercing ____ Shooting ____ Aching ____ Deep ____ Superficial ____ Tingling _____ Numbness ____ Intermittent ____ Burning ____ Stabbing

Rate your pain, at this moment, on a visual scale (0-10) 0 = no pain, 10 = excruciating: _____

Worst it has been: _____ Best it has been:_____

Are your symptoms worse in the: _____ Morning _____ Afternoon _____ Evening _____ Inconsistent

Are your Symptoms (circle one): Improving Worse Stable

Have you had past similar episodes of this current problem? If yes, were you treated with (circle disciplines, which apply): Physical Therapy, Acupuncture, Medical Doctor (Meds), Massage Therapist, Chiropractor, Pilates, General Exercise, Exercise with trainer, Self-medicated (Advil, Tylenol), ignored it, other, Did they help to alleviate your symptoms? _____

Have you undergone any special tests for this condition? (X-rays, MRI's, ETC) If yes, do you know the results:

_____

Medications (Please write in or provide a list): _____

_____

Any Allergies: _____

Please answer the following questions:

	Yes	***No***
1) Do the current problems interrupt your sleep?		
2) Do your symptoms change with coughing or sneezing?		
3) Have you had any recent changes in bowel or bladder function?		
4) Do you experience any dizziness or vertigo?		
5) Have you any recent change in your weight or appetite?		
6) Do you have any bruising or bleeding disorders?		
7) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
8) Have you had a recent episode of nausea/vomiting?		
9) Do you have osteoporosis? Date or your last bone scan:		
10): Have you used steroids for any prolonged period of time?		
11) Have you noticed any shortness of breath or decrease in exercise tolerance		
12) Do you have high blood pressure?		
13) Do you have any cardiac problems?		
14) Do you have a pacemaker?		
15) Do you have diabetes?		
16) Have you ever had cancer of any sort?		
17) Are you pregnant (women only)?		

Any other illness, past injuries or medical history I should be aware of? _____

_____

Past surgeries _____ yes, _____no, give brief details: _____

_____

Sports and Exercise (type, frequency, duration) _____

_____

Goals you have for Physical Therapy:

_____

_____

Who can we thank for this referral?

_____

Patient Authorization

Release of Information & Consent to Treatment

I attest to the fact that all information herein is true and correct. I am aware of my diagnosis and wish to receive treatment at Delmarva PT, its subsidiaries, and/or affiliates. I permit its employees to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care. I give permission to Delmarva PT, its subsidiaries, and/or affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment or payment for services provided. I authorize Delmarva PT, its subsidiaries, and/or its affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I am aware of The Notice of Privacy Practices for Delmarva PT, its subsidiaries, and/or affiliates. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations. Please see associate if you wish to view a copy of The Notice of Privacy Practices

Assignment of Benefits

I authorize payment directly to Delmarva PT, its subsidiaries, and/or affiliates for services and to bill and release payment directly to Delmarva PT, its subsidiaries, and/or affiliates for any physical therapy services provided. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

I hereby waive any and all claims against Delmarva PT or any other party for any actions carried out in reliance upon the consent and permission granted herein.

The signature below certifies that I have read and understand the above information.

_____ _____

Patient or Guardian Signature Date

_____

Patient Name Printed

_____

Parent or Guardian Name Printed