

# FACILITY PATIENT INTAKE AND CONSENT FORM

Internal Use Only:

Account #

Account Type

Office #

First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Last Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Date of Injury/Onset \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Sex:  M  F Marital Status:  S  M  D  W  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_

Responsible Party \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 Relationship to Responsible Party \_\_\_\_\_

Cell Phone \_\_\_\_\_  
 Injury Area \_\_\_\_\_  
 Accident Related:  Yes  No  
 If Accident:  Auto  Work  Other  
 Nature of Accident \_\_\_\_\_  
 SS# \_\_\_\_\_

Employer \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_  
 Contact at Employer \_\_\_\_\_

Referring Physician \_\_\_\_\_

Phone Number \_\_\_\_\_

Primary Insurance \_\_\_\_\_  
 Group # \_\_\_\_\_ ID # \_\_\_\_\_  
 Insured Employer \_\_\_\_\_  
 Relationship to Insured \_\_\_\_\_

Insured Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Insured Date of Birth \_\_\_\_\_ Insured Sex:  M  F

Second Insurance \_\_\_\_\_  
 Group # \_\_\_\_\_ ID # \_\_\_\_\_  
 Insured Employer \_\_\_\_\_  
 Relationship to Insured \_\_\_\_\_

Insured Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Insured Date of Birth \_\_\_\_\_ Insured Sex:  M  F

Emergency Contact \_\_\_\_\_ Daytime Phone Number \_\_\_\_\_

Are you receiving or have you recently received home health services?  Yes  No  
 Are you receiving or have you recently received other therapy services?  Yes  No

Please initial: \_\_\_\_\_

**CONSENT TO TREATMENT:** I consent to rehabilitation and related services at FACILITY. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. \_\_\_\_\_

**TREATMENT OF MINORS:** I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. \_\_\_\_\_

**LIABILITY:** I know and agree that FACILITY is not responsible for loss or damage to personal valuables. \_\_\_\_\_

**WAIVER AND RELEASE:** I hereby release, discharge and acquit FACILITY, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. \_\_\_\_\_

**AUTHORIZATION OF PAYMENT:** I hereby assign all benefits directly to FACILITY and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. \_\_\_\_\_

**NOTICE OF PRIVACY:** I acknowledge receipt of Notice of Privacy Practices. \_\_\_\_\_

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature \_\_\_\_\_ Witness Signature \_\_\_\_\_

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of Clinic Name. This form must be completed in its entirety and must be provided to Clinic Name prior to initiation of therapy services.

U.S. PHYSICAL THERAPY MEDICAL HISTORY FORM

PATIENT NAME: TODAY'S DATE:
REFERRING PHYSICIAN'S NAME: DATE OF INJURY OR ONSET:
CAUSE OF INJURY OR ONSET: ARE YOU PRESENTLY WORKING? Y N
PRIMARY CARE PHYSICIAN'S NAME: DATE OF NEXT MD APPT:

WHAT IS YOUR REASON FOR ATTENDING THERAPY:

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

- 1.
2.
3.

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

- 1.
2.
3.

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR
DO YOU USE TOBACCO? (circle one) YES NO IF YES, HOW MUCH?

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN AND WHY

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE / WHAT WERE THE RESULTS:

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG?

CURRENT MEDICATIONS:

ALLERGIES: Medication Reaction Medication Reaction

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- ANEMIA, ARTHRITIS, ASTHMA, CANCER, CARDIO/VASCULAR PROBLEMS, HALTER MONITOR, PACEMAKER, HIGH BLOOD PRESSURE, LOW BLOOD PRESSURE, CURRENTLY PREGNANT, DIABETES, DEPRESSION, DIZZINESS/FAINTING, FRACTURES, HEADACHES, HEPATITIS / HIV, KIDNEY PROBLEMS, RESPIRATORY PROBLEMS, ASTHMA, COPD, SEIZURES, THYROID PROBLEMS

If checked any above, explain:

ANY OTHER MEDICAL PROBLEMS:

SIGNATURE OF PATIENT: REVIEWED BY Therapist: Date