SPORTS CENTER PHYSICAL THERAPY

NEW PATIENT INTAKE FORM

PATIENT NAME:____________________ ____________________ ________

Last Name **First Name** **Middle Initial**

Today's Date:____________________	Date of Birth:____________________
Mailing Address:____________________ ____________________	Phone Number (best to reach you at during the day): ____________________ ☐ Cell Email Address:____________________
Responsible Party: (If Minor)____________________	How did You hear about us?__________ Returning patient? ☐ YES ☐ NO

Name of your Primary Care Doctor (PCP):____________________

Name of your Referring Physician (if other than PCP):____________________

What body part are you here for today?____________________ ☐ RIGHT ☐ LEFT

When did your symptoms begin?____________________

Was there a specific injury or event that caused this problem? ☐ NO ☐ YES (describe)____________________

____

Have you had this physical therapy for this problem before? ☐ NO ☐ YES

Have you had any other types of treatments to address this problem ☐ NO ☐ YES (circle all that apply)

massage *injections* *psychotherapy* *chiropractic* *occupational therapy* *Other:*__________

Have you seen your doctor for this problem? ☐ NO ☐ YES

List any medication(s) you take (have tried) to alleviate this problem and how often you are (were) taking them:

Prescribed:____________________

Over the Counter:____________________

Diagnostic Imaging: Have you had any of the following tests for this problem?

☐ X-Ray ☐ MRI ☐ CT scan ☐ EMG/Nerve Conduction Study ☐ Cardiac/Stress Test ☐ Other:__________

Results (if known)____________________

Have you had physical therapy this calendar year? ☐ NO ☐ YES: When were you discharged? __________

Is your injury work related? ☐ NO ☐ YES: Date of Injury: ____________________

Is your injury related to a motor vehicle accident? ☐ NO ☐ YES: Date of Accident:____________________

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SOCIAL HISTORY:

What is your Occupation?____________________

(circle one) *Full-time* *Part-time* *Retired* *Not working* *Unable to work (due to this problem)*

Job Requirements: ☐ prolonged sitting ☐ computer/desk work ☐ prolonged standing ☐ bending/lifting ☐ driving

Do you drink coffee or other caffeine containing beverages? ☐ NO ☐ YES:________ drinks/day or week

Do you smoke tobacco? ☐ NO ☐ YES: packs/day__________ Quit smoking?__________ years ago

Do you drink alcohol? ☐ NO ☐ YES:________ drinks/day or week

Do you use recreational drugs? ☐ NO ☐ YES:______times/day or week

Do you exercise regularly? ☐ NO ☐ YES: (type/frequency)____________________

Do you have hobbies or leisure activities? ☐ NO ☐ YES:____________________

MEDICAL HISTORY: Please check any conditions that you have or *have been treated for*

☐ Diabetes	☐ Stroke/TIA (mini stroke)	☐ Chemical Dependency/Alcoholism
☐ Heart Attack	☐ Coronary Heart Disease	☐ High Blood Pressure
☐ Atrial Fibrillation	☐ Thyroid Disease	☐ Depression/Anxiety
☐ Rheumatoid Arthritis	☐ Hepatitis/Liver Disease	☐ Kidney Disease
☐ Neuropathy	☐ Gout	☐ DVT/Pulmonary Embolism
☐ Lyme's Disease	☐ Osteoarthritis/DJD	☐ Fracture(s):____________
☐ Skin conditions	☐ Osteoporosis	☐ Neurological Disease
☐ Infectious Disease	☐ Immunosuppression	☐ Respiratory Disease (Asthma)
☐ Ulcers/GERD/Acid Reflux	☐ Incontinence	☐ Cancer:____________

List <u>any orthopedic surgeries</u> you have had (when/year):____________________

____

List any Allergies (food, environmental, medications, latex):____________________

____

List all medications, vitamins, herbs, supplements and over the counter drugs you currently take:____________

____

____

Any other medical history you feel is pertinent:____________________

Date of your last physical examination: ____________________

Are you pregnant or is there a possibility you may be pregnant? ☐ NO ☐ YES ☐ N/A

Nursing? ☐ NO ☐ YES Are you in Menopause/Perimenopause/Postmenopause? ☐ NO ☐ YES ☐ N/A

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If yes to the following questions, please provide specific details in the space provided (or on backside if needed):

Have you recently had any type of illness or infection? ☐ NO ☐ YES:____________________________

____

Is your Primary Care Doctor aware of the illness/infection you noted above? ☐ NO ☐ YES

Have you recently been hospitalized for any reason? ☐ NO ☐ YES:____________________________

____

Have you recently had surgery for any reason? ☐ NO ☐ YES:____________________________

____

List any equipment you currently use or that has been recommended for you to use by a medical provider: (braces, orthotic shoe inserts, cane, walker, shower chair, commode):____________________________

____

What is your main reason for coming to physical therapy today (check all that apply):

- ☐ Post/pre-surgery
- ☐ Pain
- ☐ Numbness/tingling
- ☐ Stiffness
- ☐ Weakness
- ☐ Balance loss
- ☐ Recent fall(s)
- ☐ Other:____________________

☐ Functional Impairment

Inability/difficulty doing any of the following activities:

- ☐ Bathe/Shower
- ☐ Get Dressed (shoes/socks)
- ☐ Walking (short/long distances)
- ☐ Sleeping (stomach/back/side)
- ☐ Regular Exercise Program
- ☐ Housework/School Work
- ☐ Work/Job Related Tasks
- ☐ Driving
- ☐ Sports:____________________
- ☐ Hobbies/Leisure Activities

GOALS: Please list what you hope to achieve by attending physical therapy for this problem: ____________________

____

____

ASSIGNMENT and RELEASE:

I, the undersigned, certify that I (or my dependent) have insurance coverage with ____________________ ____________________ and assign directly to SCPT all insurance benefits, if any, payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize SCPT to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that SCPT contracts internships with colleges. I authorize observation and/or treatment by said interns.

____________________	____________________	____________________
Responsible Party Signature	**Relationship**	**Date**

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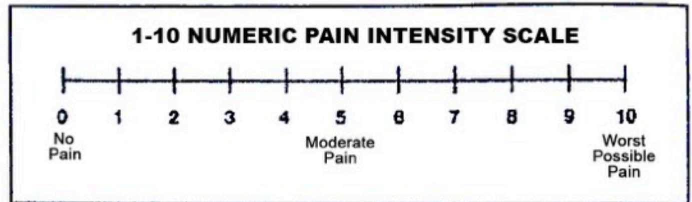
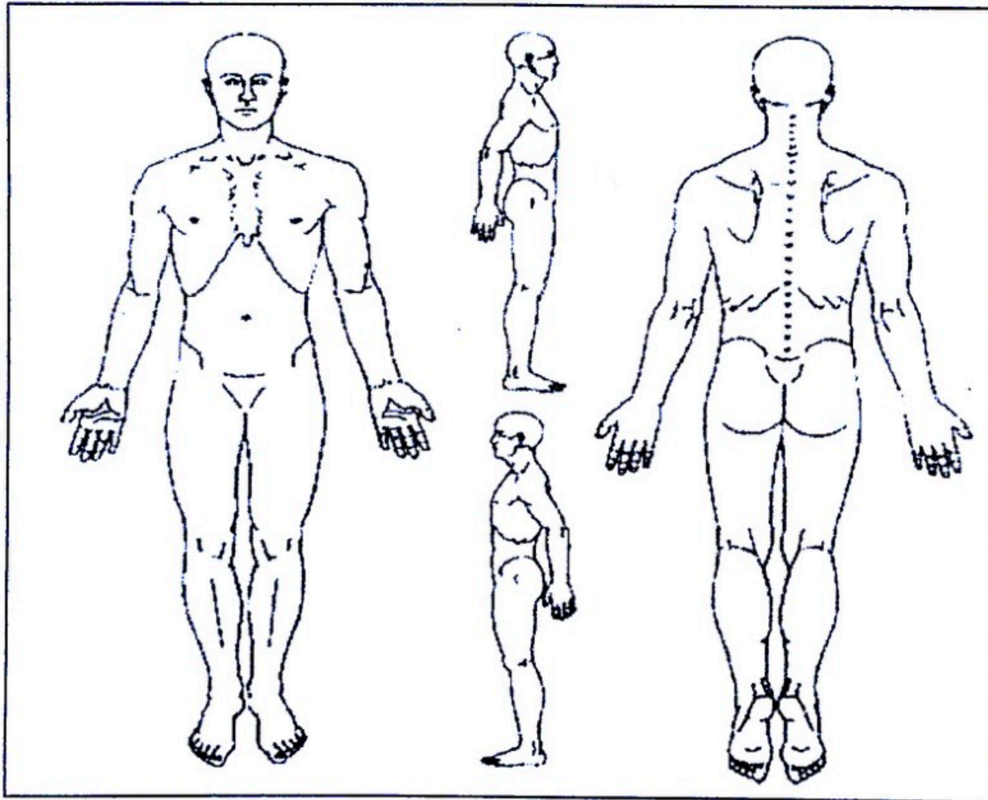
PAIN ASSESSMENT QUESTIONNAIRE

Using the following scale rate your pain on a scale of 1-10

- At this current time: ______/10
- The Worst it's been in the last 72 hours:______/10
- The Best it's been in the last 72 hours:______/10



Using the Body Diagram below, circle where the pain is located. If you have numbness indicate that using 'X X X'.
Draw arrows (⇄ ⇅) to indicate the location and direction of any radiating pain complaints that you are experiencing.



Which of the following words best describe your pain complaints? (you may circle more than one)

dull/ache burning sharp/stabbing constant comes/goes numb/tingling stiff/tightness throbbing intense

Since the onset would you say your symptoms are: ☐ getting worse ☐ improving ☐ staying the same

At what time(s) are your symptoms the **worst**? ☐ when I get up (morning) ☐ afternoon ☐ evening ☐ overnight

What, if anything, makes your symptoms **better**?______________________________

____

What, if anything, makes your symptoms **worse**?______________________________

____

Do your symptoms improve once you start moving? ☐ NO ☐ YES: ☐ within 30-60 minutes ☐ more than 1 hour

Does the pain wake you up at night? ☐ NO ☐ YES IF yes, are you able to fall back to sleep? ☐ NO ☐ YES

SPORTS CENTER PHYSICAL THERAPY

CO-PAYMENT, CANCELLATION, AND "NO SHOW" POLICY

Your insurance company may require you to pay a co-payment for physical therapy at the time of service. Many companies list the co-payment amount on the card beside OV (office visit). In some cases, physical therapy will fall under the "Specialist" co-payment listed on the card. In other cases, the co-payment may not be on the card at all, and we won't know the amount until we receive a statement from the insurance company. We encourage you to review your policy before you start physical therapy.

<u>Our Co-Payment Policy is as follows:</u>

1. Co-payments are due at the time of service provided.

2. We accept cash or checks (payable to SCPT). We also accept most credit and debit cards.

3. We do not bill for co-payments. It is the patient's responsibility to stay current with co-payments.

4. Patients under the age of 18 must have a parent or guardian sign this form. It is the parents or guardians responsibility to stay current with co-payments.

5. If benefits become exhausted or unpaid under a Motor Vehicle or Workers Compensation claim, all cumulative co-payments are due immediately as dictated by the patient's private health policy.

Appointment space is often limited in our busy practice. Many patients have an urgent need for physical therapy. It is extremely important to contact our office if you cannot make a scheduled appointment.

<u>Our Cancellation/"No Show" Policy is as follows:</u>

1. We would greatly appreciate 24 hours notice on all appointment cancellations when possible.

2. A $40 fee will be charged to patients who do not show up for a scheduled appointment and fail to contact us before that scheduled appointment time.

I acknowledge receipt of this notice______________________________ Date ______________
signature

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and shared with others and how you can access your information. It applies to any services you receive from any doctor, nurse, or licensed clinician. We are required by the Health Insurance Privacy & Accountability Act (HIPPAA) to maintain privacy of your Protected Health Information (PHI) and provide you with this notice. Please review it carefully.

In certain situations, we need to obtain your written signature in order to use and share your PHI with others. In other situations we do NOT need your signature to release information. They are as follows:

- To provide treatment and services to you. This includes referrals to specialists and calling regarding appointments.
- To obtain payment from insurers.
- For quality assurance operations or to resolve complaints.
- Disclosures to friends or relatives when your are present or available if we obtain your agreement and you do not object. If you are not present, or the opportunity to agree or object to a use or disclosure cannot reasonably be provided because or your incapacity or an emergency circumstance, we may exercise our judgement or determine whether a disclosure is in your best interest.
- We may disclose your PHI in connection with the following public health activities: (1) to report to public health authorities for the purpose of preventing or controlling disease, injury, or disability; (2) to report child or elder abuse and neglect to public health authorities of other government authorities authorized by law to receive such reports; (3) to report information about products and services that fall under the authority of the FDA; (4) to alert a person who may have been exposed to a highly contagious disease or may otherwise be at risk of contraction or spreading such a disease or condition; and (5) to report information to your employer as required under laws addressing work related injuries and illnesses or workplace medical reporting regulations.
- If we believe or have reason to know that you are or have been a victim of abuse, neglect or domestic violence, we may disclose your PHI to a governmental entity, including a social service or protective service agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.
- We may disclose your PHI in the course of a judicial or administrative proceeding in response to a court order. We may share you PHI with police or other law enforcement officials as required by law or in compliance with a court order.
- We may use or disclose your PHI to prevent or lesson a serious or imminent threat to a person's or the public's health or safety.
- Worker's Compensation. We may share your PHI as authorized by and to the extent necessary to comply with state and/or other laws relating to workers compensation or other similar types of programs.
- Disclosures to Employers. We may disclose your PHI to your employer when we provide a health care service to you at your employers request, either to (1) conduct an evaluation relating to medical surveillance of your workplace, or (2) to evaluate whether you have a work related illness or injury. Under these circumstances, we will only disclose your PHI that consist of our findings concerning your work related illness or injury or the medical surveillance of your work place, and your employer's need in order to comply with its obligations under state and/or federal laws to record work related illnesses or injuries or to conduct medical surveillance of your workplace.
- We may use and disclose you PHI to units of the government with special functions, such as the Coast Guard or the Department of State, under certain circumstances.
- As Required by the Law. We may use and disclose your PHI when required to do so by any other law not already mentioned above.

____________________________ ________________

Signature Date