Physical Therapy New Patient Intake Forms

Patient Data ______________________________ **Date** ______________

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _______

First Name ___________________ **Middle Initial** ____ **Last Name** __________________________

I prefer to be called by____

Address Line ____

City _______________________________ **State** ___________________ **Zip Code** ______________

Home Phone (_____) ________-___________ Work Phone (_____) _________-____________

Cell Phone (_____) ________-___________ Email ___________________________________

Date of Birth ______/______/_______ **Sex:** Male Female

Social Security Number: ______-_____-______ Marital Status: Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other_____

Emergency Contact ____

Contact Name ____________________________ **Relationship to Patient** ___________________

Contact Home Phone (_____) _______-________ Cell Phone (_____) ________-_____________

How did you hear about our office? ____

Patient Name ____ **Date** ________________

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _______________			

Surgeries: (Check all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Other _______________			

Allergies: (List any allergies)

Social History: (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Tobacco Use:	occasional	often	never

Sleep: Hours per night= ______

Stress Level: High Moderate Low None

Family History: (Check all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling
Other __________________		

Patient Name____**Date**_________________

Review of Systems – (Check if you have had trouble with any of the following within the last 3 months)

General:
___ Weight change
___ Fever
___ Chills
___ Night Sweats
___ Weakness
___ Fatigue

Eyes:
___ Vision
___ Pain
___ Discharge

Ears:
___ Hearing
___ Ringing
___ Pain
___ Discharge

Nose:
___ Pain
___ Bleeding
___ Taste

Mouth/Throat:
___ Sores
___ Bleeding
___ Taste

Skin:
___ Rash
___ Itching
___ Hair Changes
___ Nail Changes

Neurologic:
___ Headache
___ Dizziness
___ Fainting
___ Convulsions

G-I:
___ Appetite
___ Abdominal Pain
___ Vomiting
___ Diarrhea
___ Constipation

G-U:
___ Frequent Urination
___ Painful Urination
___ Incontinence

Cardio:
___ Murmur
___ Chest Pain
___ Palpitations
___ Difficulty Breathing
___ Cough
___ Wheezing
___ Blue Extremities
___ Swollen Extremities

Breasts:
___ Mass
___ Pain
___ Discharge
___ Self-exam

Psychologic:
___ Anxiety
___ Depression
___ Moods
___ Memory

Musculoskeletal
___ Neck
___ Upper Extremities
___ Upper Back
___ Lower Extremities
___ Lower Back

Additional Info:

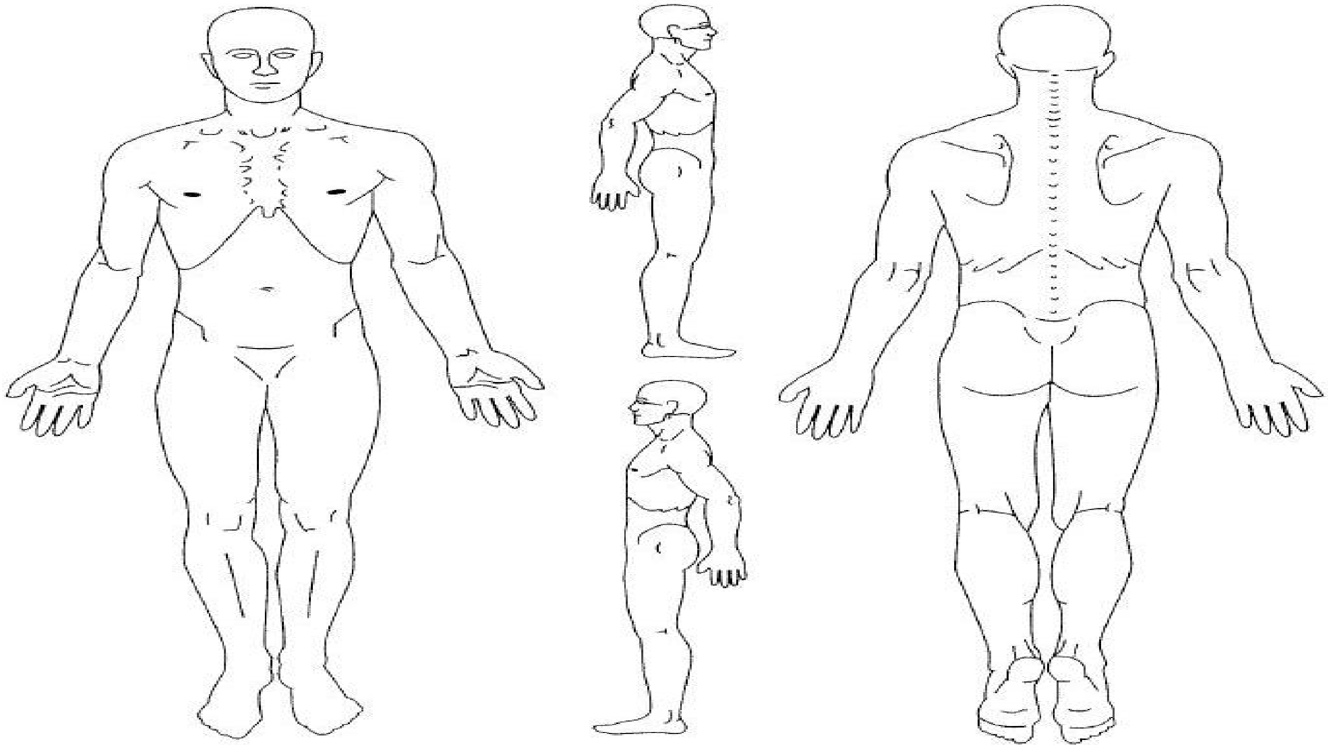
Please list **ALL** current medications and/or supplements being taken:

____
____
____

Patient Name____ Date___________________________

Are you pregnant? Yes_____ No ______N/A______

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing? 0 = no pain and 10 = the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms in order of severity, with worse symptom being #1: _______________________

____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How are your symptoms changing?

Getting better Not changing Getting worse

Patient Name ____ **Date** ____________________

Activities of Daily Living

Please circle if you have pain or difficulty performing the following:

Bending Carrying Groceries Change Position–Sit-Stand Climb Stairs Driving

Extended Computer Use Feeding Household Chores Kneeling Lift Children

Lifting Pet Care Reading (Concentration) Self Care–Bathing Self Care–Dressing

Sexual Activities Sleep Static Sitting Static Standing Walking

Yard Work Other____________________________________

What type of treatment are you looking for?

___ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem

___ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem

___ I am looking to take care of my problem and then go on to "achieve optimal health and wellness"

Cancellation Policy

We are very pleased to participate in your healthcare, and have set aside time for your appointment. We understand that sometimes it is necessary to cancel or change an appointment. In consideration of the others who need care, we ask that if you are unable to keep an appointment with our office, that you please observe our cancellation policy which follows:

Our office requires at least 24 hour notice for all appointment cancellations. If you are unable to provide 24 hour notice, you will be billed a $25.00 charge to your credit card on file for scheduled chiropractic or physical therapy appointments.

Please circle one: Visa Discover MasterCard
Card Number: ____________________________
Expiration Date: ____________________________
Cardholder: ____________________________
Signature: ____________________________

Your credit card will be charged $25.00 for missed appointments and past due balances over 30 days old.

Please sign stating you agree to the terms and conditions.

Signature ____ Date: __________________

Patient Name ____ **Date** __________________

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp

Auto Insur. Medicare Medicaid Other ___________________________________

Personal Health Insurance Carrier: _______________________ Insur. Card ID # ___________________

Policy Holder's Name: ________________________________ Group # _________________________

Policy Holder's Date of Birth ______ / _____ / ______ Primary Care Physician _________________

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____/____/____ Time: ______am / pm

If Work is responsible, Please fill out the following:

Employer Data____

Name ____
Your Occupation _________________________ **Your Job Description** _____________________
Address ____
City ________________________________ **State** _________________ **Zip Code** ______________

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name ____

Patient's Signature ____Date__________________

Consent to Treat a Minor: (Minor's Printed Name) _____________________________

Guardian / Spouse's Signature Authorizing Care _______________________________Date__________________

Complete Chiropractic Sports & Wellness

7011 Fayetteville Rd #250, Durham, NC 27713
(919) 908-7170

Physical Therapy Informed Consent Form

Informed Consent for Physical Therapy Services

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Complete Chiropractic Sports & Wellness does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Patient Name______________________**Signature**______________________________**Date**_________