REGIONAL PHYSICAL THERAPY CENTER
PATIENT INTAKE AND CONSENT FORM

Attachment B1.003A
Attachment M7.005C

Internal Use Only: A/C# Name A/C Type Office#

First Name _____ MI _____ Date of Injury/Onset _____ Today's Date _____

Last Name _____ Date of Birth _____ Age _____

Address _____ Sex ☐M ☐F Marital Status ☐S ☐M ☐D ☐W

_____ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Cell Phone _____

Responsible Party _____ E-mail _____

Address _____ Injury Area _____

City _____ Accident Related: ☐Yes ☐No

Phone Number _____ If Accident: ☐Auto ☐Work ☐Other

Relationship to Responsible Party _____ Nature of Accident _____

SS# _____

Employer _____

Address _____ Occupation _____

City _____ State _____ Zip _____ Contact at Employer _____

Referring Physician _____ Phone Number _____

Primary Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: ☐M ☐F

Second Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: ☐M ☐F

Emergency Contact _____ Daytime Phone Number _____

Are you receiving or have you received home health services? ☐Yes ☐No

Are you receiving or have you received other therapy services? ☐Yes ☐No

(Continued on next page)

REGIONAL PHYSICAL THERAPY CENTER
PATIENT INTAKE AND CONSENT FORM

Please Initial Each as Applicable:

Internal Use Only: A/C# Name A/C Type Office#

CONSENT TO TREATMENT: I consent to rehabilitation and related services at Regional Physical Therapy Center. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of sensitive nature. _____

TREATMENT OF MINORS: I, as a 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 Regional Physical Therapy Center is not responsible for loss or damage to personal valuables. _____

WAIVER AND RELEASE: I hereby release, discharge and acquit Regional Physical Therapy Center, 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 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 service 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 must be completed in its entirety and must be provided to Regional Physical Therapy Center prior to initiation of therapy services.

REGIONAL PHYSICAL THERAPY CENTER
MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____
REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____
PRIMARY CARE PHYSICIAN'S NAME: _____ ARE YOU PRESENTLY WORKING? Y ES NO
CAUSE OF INJURY OR ONSET: _____ DATE OF NEXT MD APPT: _____

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: _____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO _____

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? _____ WEAR GLASSES / CONTACTS?: YES NO

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/OCCUPATIONAL 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_____ Other _____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 CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

□ ANEMIA
□ ARTHRITIS
□ CANCER
□ CARDIOVASCULAR PROBLEMS
□ HOLTER MONITOR - currently wearing?
□ PACEMAKER
□ HIGH BLOOD PRESSURE □ controlled □ uncontrolled
□ LOW BLOOD PRESSURE
□ CURRENTLY PREGNANT
□ DIABETES □controlled □uncontrolled
□ DEPRESSION
□ DIZZINESS/FAINTING
□ FRACTURES
□ HEADACHES
□ HEPATITIS/HIV
□ KIDNEY PROBLEMS
□ MRSA (Methicillin Resistant Staphylococcus Aureus)
□ OSTEOPOROSIS
□ RESPIRATORY PROBLEMS
□ ASTHMA □ controlled □ uncontrolled
□ COPD □ controlled □ uncontrolled
□ Other
□ SEIZURES □ controlled □ uncontrolled
□ THYROID PROBLEMS
□ BLOOD THINNERS (Anticoagulants)

If checked any above, explain: _____

☐ ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____Date_____

 Revised 4.16.15 KB

Name _____

Health Screen Form

This form is intended to obtain relevant information about your health that will assist the therapist/clinician in preparing for your evaluation. Please answer all questions to the best of your knowledge.

Your Medical Status

1. Do you have high blood pressure? ☐ Yes ☐ No
2. Do you have signs of chest pain, tightness, or discomfort of the chest? ☐ Yes ☐ No
3. Do you have irregular heart rhythm or palpitations? ☐ Yes ☐ No
4. Do you have a pacemaker in place? ☐ Yes ☐ No
5. Do you have any type of electrical device implanted in your body? ☐ Yes ☐ No
6. Do you have episodes of shortness of breath? ☐ Yes ☐ No
7. Do you have any type of respiratory disorder? ☐ Yes ☐ No
8. Do you smoke? ☐ Yes ☐ No
9. Are you considered diabetic? ☐ Yes ☐ No
10. Have you had a personal history of Cancer? ☐ Yes ☐ No
11. Are you pregnant? ☐ Yes ☐ No
12. Do you exercise 2-3 times a week for 30 minutes or more regularly? ☐ Yes ☐ No
13. Have you ever been diagnosed with osteoporosis? ☐ Yes ☐ No
14. Do you have any syndrome, disease or disorder you are currently dealing with? ☐ Yes ☐ No
    If yes, list: _____
15. Have you ever had an injury, tendonitis, bursitis, arthritis or any type of joint problems? ☐ Yes ☐ No
    If yes, explain: _____
16. Have you been hospitalized in the past 6 months? If yes, explain: _____ ☐ Yes ☐ No
    _____
17. Have you received any surgical procedures in the past 6 months? If yes, explain: ☐ Yes ☐ No
    _____
18. Are you presently taking any medication? If yes, please list: _____ ☐ Yes ☐ No
    _____

_____ _____

Print your name Your Signature Date

_____

Clinician signature Date

Policy on Scheduling and Cancellations/No-Shows

It is our policy at Regional Physical Therapy Center to be as accommodating as possible to you in scheduling your therapy visits.

Your doctor has prescribed for you a certain number of visits as part of your rehabilitation treatment plan. Your therapist will review this number of visits with you during your first two visits. In addition, your therapist will review your treatment plan with you and how it relates to the number of visits prescribed.

We encourage you to schedule your visits the FIRST WEEK OF TREATMENT. We will provide you with an appointment card for your schedule.

In the event that you are unable to make one of your treatments. **PLEASE CALL 24 HOURS IN ADVANCE!** We will immediately reschedule your treatment for you.

If you do not keep a schedule appointment and have not called, we will follow up with a call to reschedule. Three no-shows are considered too long a lapse from treatment and will necessitate a new physician referral.

If you are a worker's compensation case, your insurer, employer, and physician will be notified of any missed or broken appointments.

Since we value your successful rehabilitation, we recommend attendance at all your visits ordered.

Your signature is required after you have read this policy. If you have any questions regarding this policy, please feel free to ask.

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Witness Signature Date