Patient Intake Form

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile Phone: _____ Home: _____ Work: _____

Email Address: _____

Primary Care Physician: _____ Practice: _____

Referring Physician: _____ Practice: _____

Emergency Contact: _____Phone: _____ Relationship: _____

Have you received PT or Chiropractic care from another facility in the past year? _____

If so, how many visits: _____

Is this a Worker's Compensation or Auto Claim? _____ Claim#: _____

Company: _____ Claims Adjuster: _____

Date of Injury: _____ Currently Working: Y N Late Day Worked:_____

Minors
Father's Name: _____ Phone: _____
Mother's Name: _____ Phone: _____

How Did You Hear About Us? (Please circle all that apply)

Doctor	Google Search	Instagram	Employer/Case Manager
Radio	Website	Facebook	Insurance Company
Newspaper	Location/Sign	Email	Previous Patient

Word of Mouth/Family/Friend: _____ Other: _____

Patient/Guardian Signature: _____ Date: _____

Financial Policy

Financial Policy/Insurance

- Insurance information is required at or prior to the time of the first visit
- Insurance coverage is a contract between you and your insurance company, and is billed at contracted rates
- Copays are due at the time of service
- You will be billed for any applicable deductibles, co-insurance and copays reported by your insurance company
- It is your responsibility to know and understand your insurance benefits and any covered and uncovered costs and benefits
- Insurance benefits will be verified, however this is not a guarantee of payment. Any unpaid claims are the responsibility of the client.
- Patient with insurance in which Potena Physical Therapy does not participate will be considered Self-Pay and billed at the Self-Payment rate

Missed/Cancelled Appointments

- Please provide 24 hours notice for all cancelled appointments
- Failure to attend an appointment without contacting our office is subject to a no-show fee of $25
- We reserve the right to limit scheduling for repeated cancellations or a no-show

Collections: Potena Physical Therapy will do its best to work with the needs of each client. All payments are due within 90 days of the initial invoice. In cases of unpaid balances past 90 days, and when our office has not been contacted to arrange a payment plan, the balances are subject to collections. Potena Physical Therapy uses an outside collections agency.

I acknowledge that I have read and understand the financial policies of Potena Physical Therapy, Inc

Patient Name: _____

Patient Signature:_____ Date: _____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received and reviewed a copy of Potena Physical Therapy's HIPAA Notice of Privacy Practices

Patient Name: _____

Patient Signature:_____ Date: _____

Please provide the name of person(s) to whom Potena Physical Therapy, Inc may disclose health information about your care or payment for your care

Name: _____ Relationship: _____ DOB: _____
Name: _____ Relationship: _____ DOB: _____

Office Use Only

Potena Physical Therapy made a good-faith effort to obtain acknowledgement of the notice of privacy practices from the patient named above, however it could not be obtained because:

□The individual was unwilling to sign
□An emergency prevented us from obtaining acknowledgement
□Communication barriers prevented us from obtaining acknowledgement

Staff Signature:_____ Date: _____

Health History Form

Name: _____ Age: _____ Gender: _____

Height: _____Weight: _____ Current Smoker: Y N Packs/day: _____

Pregnant: Y N Previous Children (if female): _____ Marital Status: S M D W

Assistive Device Use? Walker Cane Crutches Wheel Chair

Work Status: Retired Full-time Part-time Disabled Self-employed

Currently Working? _____ If no and not retired, date last worked: _____

Occupation: _____

Have you had any falls in the past year? Yes No If so how many?_____

PHQ-2: Over the last 2 weeks, how often have you been bothered by the following problems?
1. Little interest or pleasure in doing things _____
2. Feeling down, depressed or hopeless _____

0- Not at all 1- Several Days 2- More than half the days 3- Nearly Every Day

Medication List:
□ I do not take any medications, vitamins or supplements
If you are a Medicare Recipient, please list medications on alternate medication sheet

_____ _____ _____
_____ _____ _____

□ Asthma
□ Anxiety Disorder
□ Blood Disorder
□ Bladder Changes
□ Bowel Changes
□ Cancer
□ Cardiac Conditions
□ Chest Pain
□ CVA/Stroke
□ Depression
□ Diabetic Type I or II _____
□ Difficulty Swallowing
□ Difficult Speaking
□ Dizziness/fainting
□ Falls
□ Fever
□ Fibromyalgia
□ Fractures
□ Headaches
□ High Blood Pressure
□ HIV
□ Kidney Disease
□ Liver Disease
□ Lung Disease
□ Nausea/Vomiting
□ Numbness/tingling
□ Osteoarthritis
□ Osteoporosis
□ Pacemaker
□ Rheumatoid Arthritis
□ Ringing in Ears
□ Seizures
□ Shortness of Breath
□ Unexplained Weight Loss
□ Vision Changes
□ Other _____

Please Explain: _____
_____
_____

Relevant Surgeries and Approximate Date:(please include abdominal surgery with back pain)

_____ _____
_____ _____
_____ _____

I herby certify that the above information is complete an accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Current Condition

Reason for Today's Visit: _____Date Symptoms Started: _____

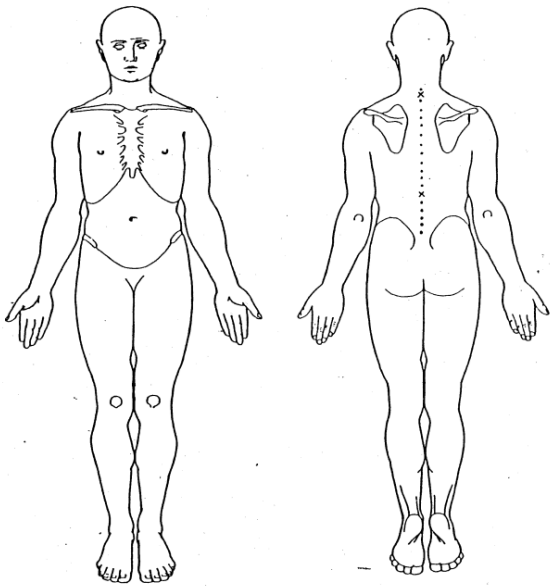
Did you have surgery for this condition: Y N Date: _____

Have you had any imaging: X-ray MRI CT-Scan Other: _____ Date: _____

Who have you seen for this condition: _____

What treatment have you tried: Injections Chiropractic Massage
Other: _____

Please Mark Location of Pain



Describe your pain:
Achey Burning Dull Deep Radiates
Sharp Stabbing Stiff Numbness
Other _____

What is your pain at its worst?
0 1 2 3 4 5 6 7 8 9 10

What is your pain at its best?
0 1 2 3 4 5 6 7 8 9 10

Average pain throughout the day?
0 1 2 3 4 5 6 7 8 9 10

Name the 3 most painful activities
1. _____
2. _____
3. _____

Name 3 activities that improve your pain
1. _____
2. _____
3. _____

Other painful activities (circle all that apply)

Walking	Standing	Steps
Sitting	Running	Bending
Driving	Lifting	Sit to Stand
Reaching	Gripping	Lying down
Turning head	Looking up	Looking down
Working	Housework	

My pain is worst at (circle all that apply) AM PM

I am having difficulty sleeping due to my symptoms: Y N

State your primary goal for therapy: _____