

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 \_\_\_\_\_

Responsible Party \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ E-mail \_\_\_\_\_

City \_\_\_\_\_ Injury Area \_\_\_\_\_

Phone Number \_\_\_\_\_ Accident Related:                      Yes                      No

Relationship to Responsible Party \_\_\_\_\_ If Accident:    Auto                      Work                      Other

Nature of Accident \_\_\_\_\_

Employer \_\_\_\_\_ SS# \_\_\_\_\_

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)

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 [Redacted]. 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 [Redacted] is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE: I hereby release, discharge and acquit [Redacted], its representatives, affiliates, employees, or assigns, of and from any and all liability, claim, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept or allow emergency and or medical services, including but not limited to ambulance and 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 \_\_\_\_\_

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**PROACTIVE PHYSICAL THERAPY  
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? YES 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)

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

If checked any above, explain: \_\_\_\_\_

ANY OTHER MEDICAL PROBLEMS: \_\_\_\_\_

SIGNATURE OF PATIENT: \_\_\_\_\_ REVIEWED BY Therapist: \_\_\_\_\_ Date \_\_\_\_\_

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