The Physical Therapy & Wellness Institute
"Bodies Under Repair"™

Patient Intake & Health History Form

Patient Information

First Name:_____ Last Name:_____ Middle Initial:____ Gender: M or F

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

Preferred Phone H/C/Wk: _____ Alternate Phone H/C/Wk: _____

Email Address: _____ Date of Birth:___-___-___ Last 4 SSN: _____

Marital Status: Single / Married/ Other Age: _____

Additional Questions/Clinical Info

Auto Related: Yes/No **Work Related**: Yes/No **Accident Related**: Yes/No

Body Part: _____ **Right or Left** **Date of Injury**: _____ **Mechanism Of Injury**: _____

Rate Your Pain: **0** _____ **5** _____ **10** **Current Pain Level:** ____/10 **Pain At Worst** ____/ 10 **Pain At Best:** ____/10
No Pain Most Severe Pain

Have you had diagnostic tests performed for this injury: Y/N **MRI**: Y/N **X-Ray**: Y/N **Where were they performed**: _____

MEDICARE ONLY

Are you currently receiving home health care services? Yes/No **Name of Agency**:_____ Phone:_____
If Yes, what type of home health care services: _____ **Last date of service**: _____

Have you received PT, OT or Speech therapy services since the first of the year? Yes/No **Height**:_____ **Weight**:_____
Have you fallen in the past 6 months? Y or N **Have you fallen in the past 12 months? Y or N**
Would you like us to perform a fall risk safety assessment of your home? Y or N

Patient Goals

My Goals in coming to Physical Therapy are:

To Get rid of my Pain _____
To Get Stronger _____
To Improve Range of motion _____
Other: _____

To Improve Sports Performance: _____
To Improve my Work abilities: _____
To get better with my home activities _____
To Improve function around the house _____

Emergency Contact

Contact Name: _____ Relationship to Patient: _____ Phone Number: _____

If patient is a minor: Guardian: _____ Phone Number: _____

Physician Information

Name of Referring Physician: _____ Name of the 1st Doctor you saw for this onset?: _____

Family Physician: _____ Phone Number: _____

Do you have a scheduled return date to see the referring doctor? Y / N. **If yes**, when are you scheduled to return to the doctor? _____

Employer Information

Employer Name:_____ Employment Status: ___ Full Time ___ Part Time ___ Retired ___ Student

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Work Phone Number: _____ Patient Occupation: _____ Modified Duty: Y/N

How did you hear about us?

My Doctor referred me here ____
List Provided by my Doctor ____
Worker's Comp Panel ____
Previous Patient ____
Insurance List ____
Website ____
Family/Friend ____ Their Name: _____
Mailing Card ___ Home Health Care/Name & Phone # _____
Other (explain) _____

Medications: (please indicate dose, frequency)

Drug:

__Fentanyl __ Duragesic __ Hydrocodone __ Vicodin __ Morhone __ Dilaudid __Tylenol/codient

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____

Other Medications (indicate dose/frequency)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical History	Yes	No		Yes	No
Allergies	☐	☐	Gallbladder Problems	☐	☐
Anemia	☐	☐	Hepatitis	☐	☐
Anxiety	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	Incontinence	☐	☐
Asthma	☐	☐	Kidney Problems	☐	☐
Cancer	☐	☐	Metal Implants	☐	☐
Cardiac Conditions	☐	☐	Multiple Sclerosis	☐	☐
Cardiac Pacemaker	☐	☐	Osteoporosis	☐	☐
Chemical Dependency	☐	☐	Parkinson's	☐	☐
Circulation Problems	☐	☐	Rheumatoid Arthritis	☐	☐
Currently Pregnant	☐	☐	Seizures	☐	☐
Depression	☐	☐	Speech Problems	☐	☐
Diabetes	☐	☐	Strokes	☐	☐
Dizzy Spells	☐	☐	Thyroid Disease	☐	☐
Emphysema/Bronchitis	☐	☐	Tuberculosis	☐	☐
Depression	☐	☐	**Other:**		

I consent to Physical Therapy and Wellness Institute (PTW) for treatments/procedures that are necessary or advisable for my care. I authorize PTW to exchange with and/or release requested information on my medical care to my insurance carrier and any other parties involved in your case.

_____ _____

Patient's Signature Date

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due by my insurer to Physical Therapy & Wellness Institute. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information from Physical Therapy & Wellness Institute.

_____ _____

Patient's Signature Date

I have read and understood Physical Therapy & Wellness Institute's privacy notice. I further that I may obtain a copy of this privacy notice upon request.

_____ _____

Patient's Signature Date

I have read and understand Physical Therapy & Wellness's billing and collection policies, The Financial Policy, cancellation and now show policies. I further understand that I may obtain a copy of this policy upon my request.

_____ _____

Patient's Signature Date

_____ _____

Responsible Party's Signature (if patients is a minor) Date

Now the easy stuff:

Patient Agreement:
I agree to attend when scheduled. (Cancellations affect 3 people – Your Therapist, the patients wanting appointments, and your recovery)
I agree to be respectful towards other patient's privacy.
I agree to give good effort in my rehabilitation program.

PTW Agreement:
We agree to have staffing available to attend your needs, treat you with the respect you deserve, and are honored you have chosen us to help
We agree to give you the privacy that you expect.
We agree to provide you with quality Physical Therapy to help you achieve a higher level of performance at *your body repair stop*.