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 (Scale)**: **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 Improve Sports Performance: _____
To Get Stronger _____ To Improve my Work abilities: _____
To Improve Range of motion _____ To get better with my home activities _____
Other: _____ 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 ____ Previous Patient ____ Family/Friend ____ Their Name: _____
Their Address: _____

List Provided by my Doctor ____ Insurance List ____ Mailing Card ___ Home Health Care/Name & Phone # _____
Worker's Comp Panel ____ Website ____ 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 | ☐ | ☐ |
| | | | **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 no 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*.