

CENTRAL MASS Physical Therapy & WELLNESS

PATIENT DEMOGRAPHICS: INTAKE FORM

CONFIDENTIAL PATIENT INFORMATION

First Name: _____ Last Name: _____

Preferred First Name: _____ Date of Birth: _____ Gender: *M* *F*

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Ext: _____ Email: _____

Best way to contact you: _____

Occupation: _____

HEALTH INSURANCE INFORMATION

Insurance Type: _____ Member ID/Policy #: _____

Primary Insured Name: _____ Relationship: _____

Primary Insured Date of Birth: _____ Primary Insured Address: _____

REFERRAL INFORMATION

How did you hear about us? _____

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____

****Please note:** *Our time is valuable too- if you do not show for a scheduled appointment, or neglect to cancel 24 hours prior to your appointment, you will be charged a \$50 no-show fee.*

Signature- _____ Date- _____

CENTRAL MASS Physical Therapy & WELLNESS

Medical History: Intake Form

Name: _____

Date of Birth: _____

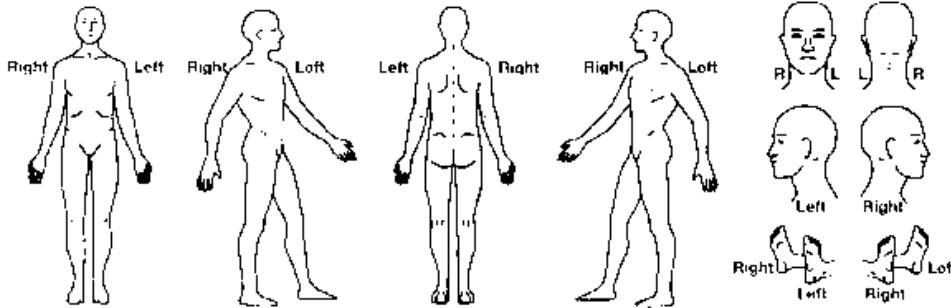
CURRENT INJURY REPORT

Chief Complaint: _____

This injury is a result of: Sports Work Trauma Chronic Other: _____

Date of onset: _____

Please mark where you are currently experiencing pain:



Type of pain- Sharp Dull
 Achy Burning Deep
 Stabbing Throbbing
 Shooting Other: _____

Do your symptoms spread?
 Yes No
 If yes, where? _____

How often do you experience these symptoms? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Rate your current pain (0-10): _____ Pain at worst (0-10): _____ Pain at best (0-10): _____

Symptoms are worse in the: Morning Afternoon Evening Inconsistent

Symptoms are: Improving Worse Stable

Have you had this condition in the past? If so, when and what treatment did you receive? _____

Please list any x-rays, MRI, or CT Scans you have had for your current condition: _____

Please list any treatments you have already sought out for your current condition (injections, surgery, massage, acupuncture, chiropractor, etc...): _____

Name: _____

Date of Birth: _____

MEDICAL HISTORYDo you exercise regularly? Yes No

If yes, how often and what type? _____

Do you wish you could exercise more? _____

If so, what is preventing this? _____

Recreational Activities/Hobbies: _____

How many hours per week do you spend sitting at a desk? _____

How do you spend most of your work days (sitting, standing, driving, walking, etc...)? _____

Please list any medications you are currently taking: _____

Do you have any allergies? Yes No

If yes, please list: _____

Please list any previous surgeries or serious traumas-

1- _____ Date: _____

2- _____ Date: _____

3- _____ Date: _____

Do you have, or have you ever had, any of the following diseases or conditions? Check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Total Joint Replacement | <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Emphysema/Glaucoma |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shingles | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Head Injury or Concussions |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Other _____ |

I certify that the information above is as accurate as I can provide. I further understand that it is my responsibility to immediately report any significant change in the information above or my condition to my physical therapist.

Signature- _____

Date- _____

CENTRAL MASS Physical Therapy & WELLNESS

Consent to Treatment

I, the undersigned, a patient at Central Mass Physical Therapy & Wellness ("CMPTW"), do hereby authorize the licensed physical therapy staff to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and me. Furthermore, I understand that CMPTW will prepare insurance forms, and will bill only as a courtesy my insurance company directly. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Deductibles/Percentages pays and/or Co-payments

Co-payments are to be paid at time of service, unless prior arrangements have been made with the Office Manager. Deductible and percentage payment amounts will be billed at the time the payment from your insurance company is received. Payment is due within 30 days of the date of the invoice. Patients are to keep payments current.

Cancellation/No-Show Policy

I understand that cancellations should be made at least 24 hours prior to my scheduled appointment(s), unless extenuating circumstances prevent otherwise. **The fee for no-shows is \$50.00.** Appointments will be classified a no-show if cancellations are made the same day of my scheduled appointment(s).

By signing below you are agreeing to all the terms and conditions.

Patient signature: _____

Legal Guardian signature: _____

Date: _____

CENTRAL MASS Physical Therapy & WELLNESS

Acknowledgement of Privacy Practices

I have received read and understood the notice of privacy practices which has provided a complete description of the uses and disclosures of my health information as outlined by the Health Insurance Portability and Accountability Act of 1996. I understand that I have certain rights regarding my protected health information and that this information can and will be used for purposes of treatment, payment and normal healthcare operations.

Patient Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____