PATIENT DEMOGRAPHICS
INTAKE FORM

First Name:______________________________ Last Name:____

Preferred First Name:______________________________ Date of Birth:___________________ Gender: *M* *F*

Street Address:____

City:____ State:_____________ Zip:_____________________

What is the best way to contact you? ____

Cell Phone #:________________________________ Home Phone #:_____________________________

Work Phone #:______________________________ Email:____

Occupation:____

Have you had physical therapy in the last 12 months? ☐ *Yes -approximately how many visits_____* ☐ *No*

HEALTH INSURANCE INFORMATION

Please be sure you are familiar with your health plan's benefits for PT. (i.e. co-pay, deducible, number of visits allowed, authorization/referral requirements)

Insurance Type:_______________________________________ Member ID/Policy #:____________________________

Subscriber's Name:_______________________________________ Relationship:_________________________

Subscriber's Date of Birth:__________________ Secondary Insurance (Type & ID) #:_________________________

REFERRAL INFORMATION

How did you hear about us?____

Referring Physician:____ Phone #:____________________________

Primary Care Physician:____ Phone #:____________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:____ Relationship:_______________________

Home Phone #:_______________________________ Cell Phone #:_______________________________

MEDICAL HISTORY: INTAKE FORM

Describe your current problem and how it began:____

____

____

Onset Date: ______________ **This problem is from**: ☐ *Sports* ☐ *Work* ☐ *Car Accident* ☐ *Other*:___________

Describe the nature of your pain: ☐ *Sharp* ☐ Dull Ache ☐ *Shooting* ☐ *Tingling* ☐ *Other*:_____________

My symptoms are present: ☐ *Constantly (76-100% of the day)* ☐ *Occasionally (26-50% of the day)*
☐ *Frequently (51-75% of the day)* ☐ *Intermittently (0-25% of the day)*

What makes your symptoms worse? ☐ *Sitting for ___ mins* ☐ *Standing for ___ mins* ☐ *Walking for ___ mins*
☐ *Stairs* ☐ *Lying Down* ☐ *Standing up from a chair* ☐ *Reaching overhead* ☐ *Reaching behind back*
☐ *Other:*____

What makes your symptoms better? ☐ *Sitting* ☐ *Standing* ☐ *Lying down* ☐ *Walking* ☐ *Massage*
☐ *Chiropractor* ☐ *Ice* ☐ *Heat* ☐ *Rest* ☐ *Other:*____

Current Pain (0-10):__________ **Pain at Worst** (0-10):__________ **Pain at Best** (0-10):__________

How is your condition changing: ☐ *Getting better* ☐ *Getting worse* ☐ *Not changing*

Who have you seen for this condition (please list name)?
☐ *Medical Doctor:* _____________________________ ☐ *Chiropractor:* __________________________________
☐ *Massage Therapist:* __________________________ ☐ *Physical Therapist:* ______________________________
☐ *Acupuncturist:* ______________________________ ☐ *Other:* ____

Have you had imaging (x-rays, MRI, CT Scan) for this problem? ☐ *No* ☐ *Yes (details):*_______________________

How would your rate your overall health right now? ☐ *Excellent* ☐ *Very Good* ☐ *Good* ☐ *Fair* ☐ *Poor*

Do you exercise regularly? ☐ *No* ☐ *Yes, how often & what type?* ____

Recreational Activities/Hobbies:____

Preferred learning method: ☐ *Video* ☐ *Picture* ☐ *Written*

Please check all of the following that apply to you:
☐ Pain at night ☐ Asthma / difficulty breathing ☐ Diabetes
☐ Numbness ☐ Difficulty seeing or hearing ☐ Blood Disorder: ____________________
☐ Arthritis ☐ High blood pressure ☐ Cardiac Condition: __________________
☐ Osteoporosis ☐ Abnormal weight gain / loss ☐ Cancer / Tumor: ___________________
☐ Dizziness / Fainting ☐ Pain unrelieved by position or rest ☐ Urinary problems
☐ Other health problems: ____
☐ Current Medications (name & dosage) ____
☐ Prior injuries (injury & date): ____
☐ Prior surgeries (type & date): ____

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.

Consent to Treatment

I, the undersigned, a patient at Central Mass Physical Therapy & Wellness ("CMPT"), 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 CMPT 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 along with partial payment toward deductibles and co-insurance are to be paid at time of service. Payment for any remaining balance after claims process is due at time of next visit or upon receipt of statement, whichever is sooner. All patients with an insurance deductible or co-insurance will be asked to make a pre-payment at each visit, which will be credited after claims are processed by insurance.

Cancellation/No-Show Policy
Cancellations should be made at least 24 hours prior to my scheduled appointment. Our time is valuable too – if you do not show up for a scheduled appointment, or neglect to cancel 24 hours prior to your appointment, you will be charged a **$50 no-show/late cancel fee**.

Insurance Referrals
Patients are responsible to insure referrals and authorizations required by insurance companies are obtained. As a courtesy, Central Mass Physical Therapy will assist the patient with this process. Patients will be held responsible for the cost of visits that are denied by insurance because a referral or authorization was not obtained.

By signing below you are agreeing to acknowledgement of privacy practices along with all the terms and conditions listed above.

Printed Name: ____

Signature: ____ Date: __________________

Witness: ____ Date: __________________