PATIENT DEMOGRAPHICS
INTAKE FORM

First Name:_____ Last Name:_____

Preferred First Name:_____ Date of Birth:_____

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

CMPT CENTRAL MASS PHYSICAL THERAPY & WELLNESS

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 to 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 the 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.

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: _____ Date: _____

Signature: _____ Date: _____

Witness: _____ Date: _____