- Patient Intake Form -

First Name: ____________________________ **Last Name:** ______________________________

Nickname: ______________________ **Title:** ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Other: __________

Date of Birth: _____/_____/______ **Social Security #:** __________________________________

Cell or Home#: (_____) ________________________ **Work #:** (_____) _______________________

Address: ____________________________________ **City:** ______________ **State:** ___ **Zip:** _____

Email: ______________________________________ **Occupation:** ___________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced

Who may we thank for referring you to our office? _____________________________________

____

Who is your Primary Care Physician? ____

Have you had Physical Therapy since January of this year? ❑ Yes ❑ No

If so, how many visits: ___________

Have you had Home Health in the past 30 days? ❑ Yes ❑ No

____

Primary Insurance: ____________________________ **Policy #:** __________ **Group #:** __________

Policyholder's Name: _____________________ **DOB:** ___/___/___ **Relation to Patient:** _________

Secondary Insurance: __________________________ **Policy #:** __________ **Group #:** __________

CONSENT OF TREATMENT: I consent to allow a licensed physical therapist at Beyond Physical Therapy to evaluate and perform subsequent treatments with me according to his/her best judgment and knowledge.

NOTICE OF PRIVACY PRACTICE: I acknowledge that I have received a copy of Beyond Physical Therapy Privacy Notice.

CANCELATION POLICY: All appointments must be cancelled/rescheduled 24 hours prior to the scheduled appointment time. All violations will be subject to a $25.00 cancellation fee. Policy effective July 19th, 2019.

AUTHORIZATION: I authorize Beyond Physical Therapy to submit and process claims and health records to my insurance company to collect payment for services rendered. I understand that I am responsible for payment of any services rendered that are not covered by my insurance. I understand that I am ultimately responsible for paying Beyond Physical Therapy any co-pays, co-insurance, and deductibles. I also authorize Beyond Physical Therapy to discuss my condition and treatment with anyone involved with my case including but not limited to my physicians, employer, lawyer and any of their associates.

Patient Signature:_____________________________________ **Date:**________________

Parent/Legal Guardian Signature:________________________ **Date:**________________

BEYOND PHYSICAL THERAPY

Are you experiencing any of the following?

Cancer	❑ Yes	❑ No	Nausea / Vomiting	❑ Yes	❑ No
Cardiac Condition	❑ Yes	❑ No	Osteoarthritis	❑ Yes	❑ No
Chest Pain	❑ Yes	❑ No	Osteoporosis	❑ Yes	❑ No
Cough	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No
Depression	❑ Yes	❑ No	Parkinson's	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Pregnancy	❑ Yes	❑ No
Difficulty Swallowing	❑ Yes	❑ No	Rheumatoid Arthritis	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No	Seizures	❑ Yes	❑ No
Headaches	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No
Heart Attack	❑ Yes	❑ No	Speech Problems	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No	Spinal Chord Stimulator	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
HIV	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Incontinence	❑ Yes	❑ No	Vision Problems	❑ Yes	❑ No
Metal Implants	❑ Yes	❑ No	Weight Change	❑ Yes	❑ No

* If you marked yes, please provide more detail: ____

____

Allergies: ____

Please rate your pain on a scale from 0-10 (10 being the worst pain you have ever felt in your life.)

Current: ____/10 **Best:**____/10 **Worst:**____/10

Do you have any numbness or tingling? ❑ Yes ❑ No

If yes, describe where and when it happens: ______________________________________

How long ago did you get hurt? ____________ **How did you get hurt?** _____________________

When do you feel worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Sleeping

Emergency Contact: ____

Relation: ______________________________ **Phone:** (______) ________________________

Patient Signature: ____________________________________ **Date:**________________

Parent/Legal Guardian Signature:________________________ **Date:**________________