PHYSICAL THERAPY INTAKE FORM

PATIENT INFORMTION:

EMAIL ADDRESS:________________________________

FIRST NAME:	LAST NAME:	MIDDLE INITIAL:	TODAY'S DATE: / /
ADDRESS:	CITY:	STATE:	ZIP:
BIRTH DATE : / /	AGE:	☐ MALE ☐ FEMALE	S.S.#: - - *(VETERANS ONLY)
HOME #: ( ) -	MOBILE #: ( ) -	SPOUSE NAME:	
HOW DID YOU FIND OUT ABOUT US:		SPOUSE #: ( ) -	

WORK INFORMATION:

EMPLOYER:	WORK #: ( ) -	EXT:
OCCUPATION:		

CARE PROVIDER INFORMATION:

REFERRING DR:	REFERRING DR #:
REGULAR DR./PCP:	REGULAR DR./PCP#:

INSURANCE INFORMATION:

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

PRIMARY INSURANCE NAME:	
SUBSCRIBER'S NAME (IF DIFFERENT):	BIRTH DATE: / /
ID#:	GROUP/POLICY #:
PATIENT'S RELATIONSHIP TO SUBSCRIBER : ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:	

IN CASE OF EMERGENCY:

NAME OF LOCAL FRIEND OR RELATIVE:		
RELATIONSHIP TO PATIENT:	HOME#: ( ) -	MOBILE#:( ) -

I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO ACTIVE LIFE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE ACTIVE LIFE TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

____

PATIENT / GUARDIAN SIGNATURE DATE

BLOOD PRESSURE:	YES	NO	JOINT CONDITIONS:	YES	NO
HYPERTENSION			UPPER EXTREMITY		
LOW BLOOD			DISLOCATION		
NORMAL BLOOD PRESSURE			LOWER EXTREMITY DISLOCATION		
HEART DISEASE:	**YES**	**NO**	**OTHER CONDITIONS:**	**YES**	**NO**
HEART ATTACK			MUSCULAR DYSTROPHY		
ARTHEROSCLEROTIC DISEASE			RHEUMATOID ARTHRITIS		
MYOCARDIAL INFARCTION			MULTIPLE SCLEROSIS		
RHEUMATIC HEART DISEASE			EPILEPSY		
HEART MURMUR			GOUT		
DO YOU HAVE A PACEMAKER			FIBROMYALGIA		
MUSCLE CONDITION:	**YES**	**NO**	DIABETES		
CARPAL TUNNEL R/L			HEARING LOSS		
TENNIS ELBOW R/L			POOR EYESIGHT		
BACK/NECK PROBLEMS			FAINTING		
LIMITED LIMB MOVEMENTS			CANCER(PRESENTLY OR HISTORY OF)		
LUNGS:	**YES**	**NO**	OTHER:		
ASTHMA					
EMPHYSEMA					
SHORTNESS OF BREATH					

EXERCISE:	WORK ACTIVITY:	STRESS LEVEL:	HABITS:
NONE	SITTING	LOW	SMOKING – HOW MANY PACKS______
1-2 X WEEK	STANDING	MEDIUM	ALCOHOL- DRINKS A WEEK ______
3-4 X WEEK	LIGHT LABOR	HIGH	COFFEE/SODA – CUPS A WEEK ______
5+ X WEEK	HEAVY LABOR		

ARE YOU TAKING ANY SEIZURE MEDICATION? YES☐ NO☐ IF YES LIST NAME: ____

ARE YOU TAKING ANY MEDICATIONS THAT MIGHT AFFECT YOUR LUNGS, HEART, CONSCIOUSNESS OR GERERAL WELL-BEING WHILE PARTICIPATING IN THERAPY? YES☐ NO☐ IF YES LIST NAME: ____

LIST ALL MEDICATIONS YOUR ARE CURRRENTLY TAKING: ____

____

LIST ALL SURGERIES IN THE PAST TWO YEARS (INCLUDING DATES): ____

ARE YOU PREGNANT? YES☐ NO☐ IF YES, WHAT WEEK(S)? ___________

HAVE YOU HAD ANY INJURIES RELATED TO WORK? YES☐ NO☐ IF YES LIST BODY PART AND DATE:_______________

HAVE YOU HAD ANY AUTO ACCIDENTS YES☐ NO☐ IS YES LIST BODY PART AND DATE: ________________________

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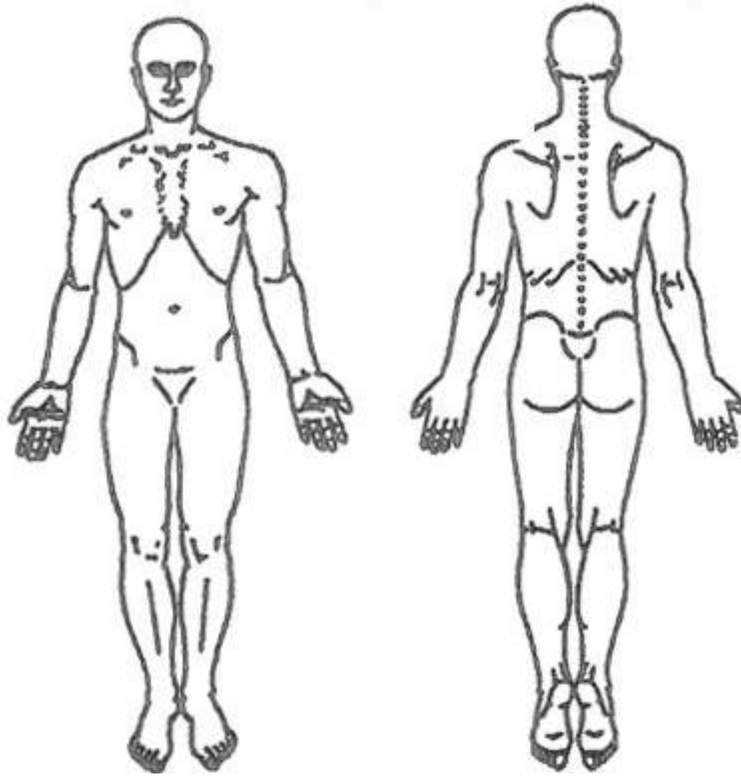
HAVE YOU HAD PHYSICAL THERAPY OR MASSAGE THERAPY BEFORE? YES☐ NO☐ IF YES, WHERE: __________________________

PAIN AND SYMPTOMS STATUS REPORT:

PLEASE CIRCLE AREAS WHERE YOU ARE HAVING PAIN:



CHIEF COMPLAINT AND VISUAL ANALOG SCALE:

MY CHIEF COMPLAINT IS:____

____

2ND COMPLAINT: ____

____

CIRCLE ON THE SCALE BELOW TO INDICATE YOUR CURRENT LEVEL OF PLAIN:											
NO PAIN	1	2	3	4	5	6	7	8	9	10	PAIN AS BAD AS IT GETS.

INSURANCE RESPONSIBILITY

Your insurance agreement is between you and the insurance company. The services we provide are due and payable at the time of service. As a courtesy, we allow our patients to use their insurance coverage in our clinic.

Please be advised that, if, for any reason your INSURANCE CARRIER denies claims for services we provided you, YOU are RESPONSIBLE for paying off the outstanding or disputed amounts.

If we have issues with your insurance claims, because Active Life was not notified of the change of coverage/information by you, the patient, or you have reached your maximum visits allowed and the claims are denied, we will no longer honor the insurance coverage and you will need to be on a CASH BASIS ONLY.

I HAVE READ AND FULLY UNDERSTAND THAT I AM EXPECTED TO MAKE SURE MY INSURANCE COVERAGE PROVIDED IS CORRECT AND UPDATED WHEN CHANGES ARE MADE. I ACCEPT RESPONSIBILITY FOR OUTSTANDING CLAIMS AND AMOUNTS.

PRINT NAME: ____

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Patient Signature **Date**

MISSED APPOINTMENT POLICY

MOST WEEKS WE HAVE A WAITING LIST FOR PHYSICAL THERAPY APPOINTMENTS. AS IS CUSTOMARY IN MOST OFFICES, A 24 HOUR NOTICE IS REQUIRED FOR CANCELLATION OR RESCHEDULEING APPOINTMENTS. FAILURE TO NOTIFY US AT LEAST 24 HOURS IN ADVANCE OF MISSED PHYSICAL THERAPY APPOINTMENTS WILL BE SUBJECTED TO THE FOLLOWING

1. **FIRST MISSED APPOINTMENT WITH OUT 24 HOUR NOTICE WILL BE CHARGED A $25 MISSED APPOINTMENT FEE. _______ (INTIAL).**

2. **THE SECOND MISSED APPOINTMENT WITHOUT A 24 HOUR NOTICE WIL BE CHARGED $25 AND YOU WILL NO LONGER BE PUT ON THE SCHEDULE. INSTEAD YOU WILL BE ON STANDBY AND MUST CALL US THE DAY YOU WISH TO BE TREATED TO SEE IF WE CAN FIT YOU IN FOR THAT DAY ________ (INITIAL).**

WE WILL DO OUR BEST TO FIT YOU IN BUT IS NO GUARANTEE THAT WE WILL BE ABLE TO ACCOMMODATE YOU ON ANY GIVEN DAY.

IF WE GIVE YOU AN APPOINTMENT WHEN YOU ARE ON STANDBY AND YOU MISS THE APPOINTMENT, YOU WILL BE DISCHARGED AS A PHYSICAL THERAPY PATIENT AND YOUR INSURANCE COMPANY WILL BE NOTIFIED THAT WE WILL NO LONGER TREAT YOU DUE TO MISSED APPOINTMENT.

PRINT NAME: ____________________________________

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PATIENT SIGNATURE **DATE**