Adult Patient Intake Form

PATIENT INFORMATION

Last Name: ______________________ First Name: ________________ Middle: ______________________
DOB: __________________ Age: ________ SSN: __________________ Sex: ◯ Male ◯ Female
Address: ____
Contact #: Cell ____________________ Home: ____________________ Work: ______________________
Emergency Contact Name: ______________________________________ Phone: ______________________
Email: ____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: _______________________ DOB: ____________ SSN: _________________________
If you are a guardian, please specify your relationship to the above patient: ____________________
Address: ____
Contact #: Cell ____________________ Home ____________________ Work ______________________
Emergency Contact Name: ______________________________________ Phone: ______________________
Email: ____

IMPORTANT

If your visit is due to a job-related injury or automobile accident, you must inform the Receptionist.

If you are receiving Home Health, you must inform the Receptionist. (Home Health could consist of someone coming to your home to give you injections, read blood pressure, give baths, or assist with medication.)

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

Subscriber's Name: __________________________ DOB: __________ Subscriber's SSN: ________________
Member's ID Number: ________________________________ Group #: ______________________________
Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Other

SECONDARY INSURANCE CARRIER

Subscriber's Name: __________________________ DOB: __________ Subscriber's SSN: ________________
Member's ID Number: ________________________________ Group #: ______________________________
Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Other

CONSENT TO THERAPY

1. **CONSENT TO TREATMENT**: I consent to rehabilitation and related services at ***Melanie Massey Physical Therapy***. In doing so, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching, and direct contact of a sensitive nature.
2. **TREATMENT OF MINORS**: I, as parent/guardian of a minor receiving treatment hereunder, do at this moment agree and understand that I have been advised of ***Melanie Massey Physical Therapy's*** waiting room policies and treatment.
3. **LIABILITY**: I know and agree that ***Melanie Massey Physical Therapy*** is not responsible for loss or damage to personal valuables.
4. **WAIVER AND RELEASE**: I hereby release, discharge and acquit ***Melanie Massey Physical Therapy***, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

5. **AUTHORIZATION OF PAYMENT**: I at this moment assign all benefits directly to ***Melanie Massey Physical Therapy*** and also authorize the release of any medical records necessary to facilitate my treatment process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

DISCLOSURE AUTHORIZATION – FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I have read and fully understand **Melanie Massey Physical Therapy** Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available in the front waiting area, or a hard copy may be obtained upon request. I understand that **Melanie Massey Physical Therapy** may use or disclose my personal health informationto carry out treatment, obtain payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice.

I at this moment consent to the use and disclosure of my personal health information for purposes as noted in **Melanie Massey Physical Therapy** Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

COMMUNICATION OF HEALTH INFORMATION

I permit ***Melanie Massey Physical Therapy*** to disclose and discuss any information related to my medical condition(s) with the following individuals:

Name: ______________________________ Relationship: ____________________
Name: ______________________________ Relationship: ____________________
Name: ______________________________ Relationship: ____________________

CONTACT INFORMATION

I wish to be contacted in the following manner(s):

Home Telephone

- ☐ OK to leave a message with detailed information
- ☐ Leave a message with the call-back number only
- ☐ OK to leave a message with family members or other persons living in the same household

Work Telephone

- ☐ OK to leave a message with detailed information
- ☐ Leave a message with a call-back number only
- ☐ OK to leave a message with a secretary, assistant, or another individual who regularly answers the phone

Cellular Telephone

- ☐ Ok to leave a message with a call-back number only
- ☐ OK to leave a message with detailed information

FINANCIAL POLICY

Thank you for choosing ***Melanie Massey Physical Therapy*** as your therapy provider. We are committed to providing the best possible care for you. To achieve this goal, we need your assistance in understanding our payment policy. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policy. Please read and sign before your treatment.

Payment of services is due before or upon completion of each treatment visit. We accept ***CASH, MASTERCARD, VISA, DISCOVER***, ***CARECREDIT, and PERSONAL CHECKS***. Once your complete insurance information is on file, we will be happy to submit your claims to your insurance company.

NO-SHOW & CANCELATION POLICY

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival may result in a shortened treatment or cancellation. No-show is someone who misses their appointments without canceling.

Our front desk staff will attempt to call and reschedule, but if there are unsuccessful attempts to make-up or reschedule and you have three in a row no-show, we will remove you from our reoccurring appointment schedule. We will be happy to assist you with any available appointment.

AGREEMENT

I have read and agree to all of the above (Consent to Treat, Financial Agreement, Notice of Privacy Policy, Communication Policy, and No-Show and Cancellation Policy).

Patient/Guardian Signature: ______________________________ Date: ______________

Patient/Guardian Print: ______________________________

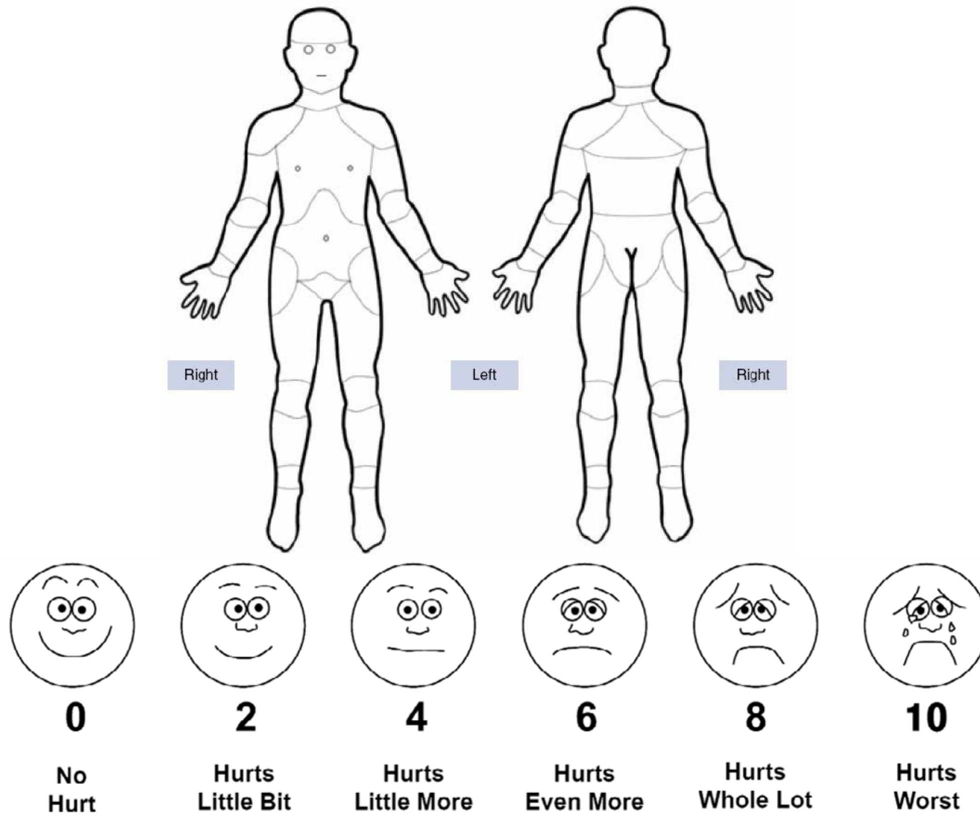
Witness Signature: ______________________________ Date: ______________

Medication

Are you currently taking any medications? If so, please list any prescriptions, over the counter, herbals, and vitamin/mineral/dietary (nutritional) supplements and include the drug name, dosage frequency, and route. List any allergies to medications or other allergies you may have such as latex.

Name & Purpose	Dosage	Frequency	Route
Tramadol-pain	*50 mg*	*daily*	*Oral, topical, Intravenous*

Pain Information



Your Pain: Indicate your level of pain by circling a number 0-10

My worst pain is	0 1 2 3 4 5 6 7 8 9 10
My least amount of pain over the last week	0 1 2 3 4 5 6 7 8 9 10
My current pain is	0 1 2 3 4 5 6 7 8 9 10

Do you have times where you are pain-free? Yes or No
What percentage of the time are you pain-free? ____%
Briefly describe your symptoms: ____

____

____

Do you have any numbness/tingling? Yes or No If so, where? ______________________
Do you have any weakness? Yes or No If so, where? ___________________________
Date your symptoms began? ____
How did your symptoms begin? ____
What increases your symptoms? ____
What relieves your symptoms? ____
Symptoms worse AM or PM with or without activities? ___________________________
What type of diagnostic testing have you had? Circle

X-Ray MRI CT Scan EMG Bone Scan Lab Test

Date performed: ____
Results of Imaging: ____
Previous treatment for this condition? _________________________________
Have you fallen in the last year? Yes or No
If yes, how many times have you fallen? ____________________________
Were you injured when fell? _____________________________________
List any allergies to medications or other allergies you may have such as latex:

____

____

Have you ever been diagnosed with the following conditions?

Y / N Cancer If yes, what kind?____
Y / N High Blood Pressure
Y / N Heart Problems If yes, what kind? _____________________________________
Y / N Hepatitis
Y / N Tubrculosis
Y / N Stroke
Y / N Kidney Disease If yes, what kind? _____________________________________
Y / N Blood Clots/ Difficulty Clotting
Y / N Chemical Dependency (i.e. alcoholisim)
Y / N Circulation Problems
Y / N Asthma
Y / N Stomach Ulcers
Y / N Arthritis
Y / N Rheumatoid Arthritis
Y / N High Colesterol
Y / N Thyroid Problems Hypo/Hyper
Y / N Diabetes
Y / N Multiple Sclerosis
Y / N Lyme Disease
Y / N Depression
Other ____

Please circle any of the following that is NEW or UNUSUAL for you

Y / N Weight Loss/Gain
Y / N Nausea/Vomiting
Y / N Dizziness/Lightheadedness
Y / N Fatigue
Y / N Weakness
Y / N Fever/Chills/Sweats
Y / N Numbness/Tingling
Y / N Tremors
Y / N Seizures
Y / N Double Vision or Loss of Vision
Y / N Eye Redness
Y / N Bowel/Bladder Dysfunction

Please list any significant injuries (fractures, dislocations, etc.) or surgeries and their approximate date
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