PHYSICAL THERAPY INTAKE FORM

Name: ______________________________ DOB: ____________ Age:__________

Home Address: ______________________ City: ____________ State/Zip: __________

Email Address: ____

Home Phone Number: ____________________ Mobile Number: ________________

Occupation: ______________________ Work Phone:____________________

Employer: ______________________ Phone Number: ________________

Employer Address: ____________________City: __________ State/IL:____________

How did you hear about us? ______________________________

REFERRING PHYSICIAN INFORMATION

Physician Name: ______________ Phone Number: __________Fax Number: __________

Address: ____________________ City: __________ State/Zip: ____________

INSURANCE INFORMATION

Insurance Provider: __________ ID Number: ____________ Group Number: __________

Policyholder: ______________ DOB: ______________ Phone: ____________

Address: ____________________ City: ______________ State/Zip:__________

SECONDARY INSURANCE INFORMATION

Insurance Provider: __________ ID Number: ____________ Group Number: __________

CURRENT COMPLAINT

Current Complaint: ____

When did you symptoms start: ____

What makes your symptoms worse? ____

What makes your symptoms better? ____

Have you fallen in the last year? ____

Current symptoms are: Getting Better Worse No Different

Current Symptoms : Come and go Constant Constant but change with activity

Have you received treatment for this condition? ____

What type of medical care? ____

Imaging: MRI Xray CT Scan

Are you currently working? Full Duty Light Duty Not Working- Date of Last Day:________

Job Demand: Light Medium Heavy

Goals for Therapy : ____

____

MEDICAL HISTORY

Please check the following:

Shortness of breath Dizziness/Nausea Instability Fatigue

Weakness Numbness/Tingling Weight Loss/gain Night Pains

Change in bowel/bladder Headaches Fever/Chills

Please list any past medical history, surgeries, and illnesses that may affect our therapy.

____

____

Will you or your child require special/specific accommodations during treatment or when learning new exercises?If so, please list the needed accommodations:____

____

Please list any medications.

____

____

HIPAA AUTHORIZATION FORM

I,______________________________, hereby authorize PPC and its employees, to access and/or release my personal health information obtained by examination, evaluation or treatment provided by PPC (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for communication regarding my condition in compliance with HIPAA regulations. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.
Consent to treat- I consent to and authorize my physical therapist to provide hands on examination, evaluation, assessment and treatment necessary to resolve my health condition.
Payment- I agree to pay all co-payments, coinsurance at the time of service and I acknowledge that I am financially responsible for the entirety of my physical therapy bill (after insurance or cash based).
Cancellation policy- I agree to provide 24 hours notice of a cancellation to provide the therapist sufficient time to make accommodations to schedule.
Photo and video release- I hereby grant PPC the permission to use photograph, video, or other digital media to evaluate and treat my condition. I understand and agree that all photos will become the property of PPC and will not be returned. I understand the photos may be used in research, advertising and/or projects to demonstrate therapeutic interventions. I hereby irrevocably authorize PPC to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I understand that I have a right to revoke this authorization by providing written notice to PPC. However, this authorization may not be revoked if PPC , it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

Emergency Contact/Relationship: ____

Phone Number: ____

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for/or coverage of services. This authorization is valid from the date of my/my representative's signature below.

Name: ____

Signature: ____

Parent/Guardian Signature:____

Date: ____