



creating an environment for wellness and healing

Intake Information

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Occupation \_\_\_\_\_ Doctor \_\_\_\_\_

What are your primary symptoms for which you are being seen in physical therapy? \_\_\_\_\_

When and how did this problem begin? \_\_\_\_\_

Was this a result of an injury? Yes No Work injury? Yes No Gradual onset? Yes No

When it started \_\_\_\_/\_\_\_\_/\_\_\_\_ When it became worse \_\_\_\_/\_\_\_\_/\_\_\_\_

Please list 3 things you are unable to do:

- 1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please rate your pain from 0-10 (0 = No Pain, 10 = Emergency Room Pain):

Least Pain Rating \_\_\_\_\_ Occurs During \_\_\_\_\_

Most Pain Rating \_\_\_\_\_ Occurs During \_\_\_\_\_

Please check the following symptoms or activities that increase your symptoms:

- \_\_\_ Sit \_\_\_ Stand \_\_\_ Rise from chair \_\_\_ Overhead reach
\_\_\_ Walk \_\_\_ Bend \_\_\_ Backward \_\_\_ Forward
\_\_\_ Sleeping \_\_\_ Constant \_\_\_ Rolling in bed \_\_\_ Cooking
\_\_\_ Lying on the affected side \_\_\_ Coughing, sneezing, straining \_\_\_ Driving

I feel best in the (Please circle) AM PM

I feel worst in the (Please Circle) AM PM

Please describe your pain:

- \_\_\_ At rest \_\_\_ Stays in one place \_\_\_ Better with activity \_\_\_ Worse with activity
\_\_\_ Occasional \_\_\_ Sharp \_\_\_ Throb \_\_\_ Pins/Needles
\_\_\_ Ache \_\_\_ Tingling \_\_\_ Pain moves around \_\_\_ Giving way

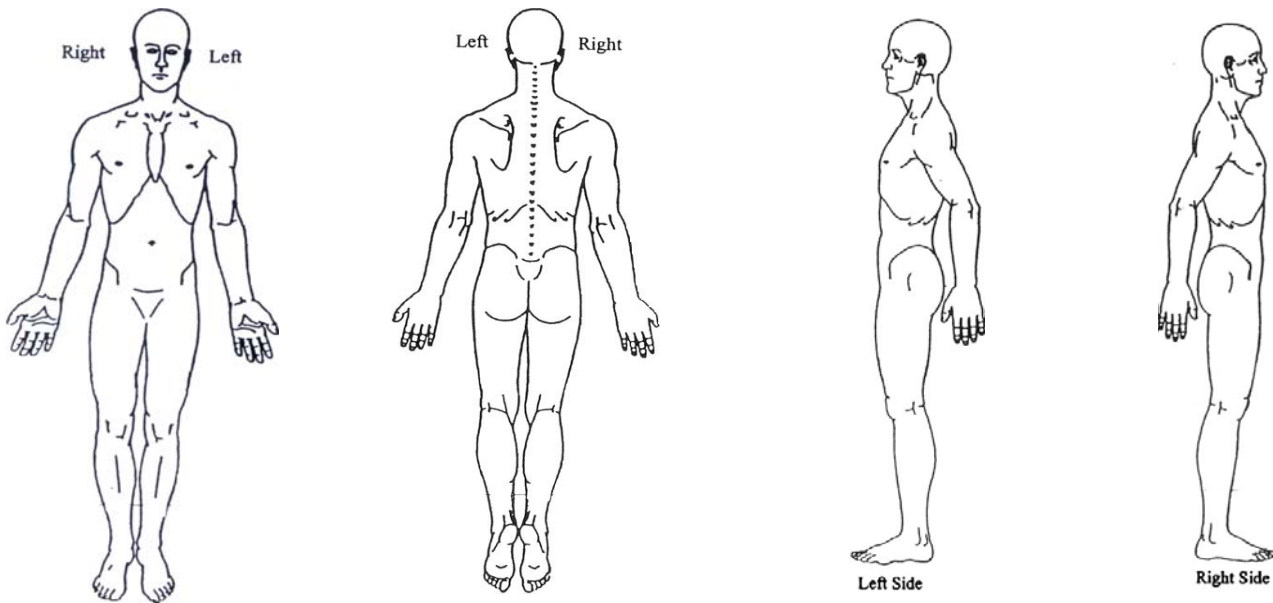
What treatments have you had for this condition? (Please include dates and whether or not the treatment helped.)

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Please indicate as specifically as you can on the body chart where you experience your symptoms.



Do you currently have any of the following? (Please circle)

Dizziness:	Yes No	Pregnancy:	Yes No	Latex Sensitivity:	Yes No
Vision Problems:	Yes No	Hearing Problems:	Yes No	Numbness/Tingling:	Yes No
Fever/Sweat/Chills:	Yes No	Malaise:	Yes No	Nausea/Vomiting:	Yes No
Numbness:	Yes No	Weakness:	Yes No	Night Pain:	Yes No

Bowels/Bladder problems:	Yes No	Unexplained weight loss:	Yes No
Urinary frequency changes:	Yes No	Sexual dysfunction/Pelvic pain:	Yes No
Tendency to Bleed/Bruise easily:	Yes No	Metal Implants (Joint Replacement):	Yes No

Alcohol Consumption: Yes No    How much? \_\_\_\_\_    Smoke? Yes No    \_\_\_\_\_ pack per day

Cholesterol: High Low Normal    Steroid use? Yes No

Allergies (Medications, seasonal, other) \_\_\_\_\_



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Have you or your immediate family ever had any of the following?

(Please circle F for immediate family and S for self)

- |                     |     |                     |     |                            |     |
|---------------------|-----|---------------------|-----|----------------------------|-----|
| Asthma              | S F | Heart Attack        | S F | Anemia                     | S F |
| Allergies           | S F | Pacemaker           | S F | Head Injury                | S F |
| Chronic Bronchitis  | S F | Thyroid Problems    | S F | Osteoporosis               | S F |
| Emphysema           | S F | Diabetes            | S F | Parkinson's                | S F |
| Lung Problems       | S F | Muscular Dystrophy  | S F | Stroke/TIA                 | S F |
| Kidney Problems     | S F | Multiple Sclerosis  | S F | Depression                 | S F |
| On Dialysis         | S F | Tuberculosis        | S F | Seizures                   | S F |
| Heart Disease       | S F | Cancer              | S F | Degenerative Arthritis     | S F |
| High Blood Pressure | S F | Back/Neck Problems  | S F | Rheumatoid Arthritis       | S F |
|                     |     | Chemical Dependency | S F | Other Arthritic Conditions | S F |

Other: \_\_\_\_\_

During the past month, have you often been bothered by feeling down, depressed, or helpless? Yes No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes No

Recent Surgeries or hospitalizations in the past 12 months? (appendectomy, gallbladder, etc.)

- \_\_\_\_\_ Date \_\_\_\_\_
- \_\_\_\_\_ Date \_\_\_\_\_
- \_\_\_\_\_ Date \_\_\_\_\_

Past Medical History (back/neck/ankle/knee problems, other surgeries, pregnancies, strains, sprains, etc.)

- \_\_\_\_\_ Date \_\_\_\_\_
- \_\_\_\_\_ Date \_\_\_\_\_
- \_\_\_\_\_ Date \_\_\_\_\_

Present Medications	Dosage	Physician

Tests and Results (X-rays, MRI, CT scan, EMG, Other)

- \_\_\_\_\_ Date \_\_\_\_\_
- \_\_\_\_\_ Date \_\_\_\_\_
- \_\_\_\_\_ Date \_\_\_\_\_
- \_\_\_\_\_ Date \_\_\_\_\_



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What are your expectations/goals for therapy?  
\_\_\_\_\_

ARE YOU CURRENTLY RECEIVING ANY HOME HEALTH THERAPY OR ANY THERAPY (MD, DO, Dentist, Psychiatrist/Psychologist, Chiropractor, Other) ANYWHERE ELSE? Yes No

WHAT KIND AND WHERE? \_\_\_\_\_

### **REHABILITATION PROGRAM**

Following your evaluation, your therapist will discuss your **diagnosis, treatment program and plan** as well as the **potential for improvement and frequency and duration** of your program. Normally, treatments can last from **30 minutes to 1 hour**. Please keep your therapist informed of your **next doctor visit**, hopefully at least 2 days prior to the visit, so that we may retest you prior to your visit and share the results with your physician.

Your **exercise program** will be upgraded as you progress, usually each visit. You will also be given a Home Exercise Program. Both programs are vital to your success. The **primary goal** of the program is to decrease pain, increase flexibility, strength, and endurance, as well as general function. Another goal is to educate you and enable you to return to work, seek employment, or return to your previous level of activity.

**Cold water** is available during your exercise program. Please ask any staff member if you need help. **Smoking** is only allowed outside at rear exit at least 20 feet from the door entrances.

**Patients will be discharged** from the program for the following reason(s): a) goals are met; b) compliance problems- exercise absences, tardiness, or lack of cooperation/poor motivation; c) lack of progress; d) other medical complications.

### **CONSENT FOR CARE AND TREATMENT**

I, the undersigned, do hereby agree and give my consent for Advanced Physical Therapy to provide medical care, evaluation, and treatment to (patient's name) \_\_\_\_\_ considered necessary and proper in diagnosing or treating his/her physical and medical condition.

### **BENEFIT ASSIGNMENT/RELEASE OF INFORMATION**

I hereby assign all medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to Advanced Physical Therapy. I understand that Advanced Physical Therapy agrees to accept the charge determination of the Medicare/Medicaid carrier as the full charge, and the patient is responsible only for the deductible, co-payment not covered by any supplemental coverage, and any non-covered services including supplies. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Advanced Physical Therapy to copy my driver's license to verify that I am the patient receiving the services and to release all information necessary, including Medical Records, to secure payment. I acknowledge that Advanced Physical Therapy provided me with the opportunity to read a copy of the Notice of Privacy Practices and ask questions.

### **FINANCIAL POLICY STATEMENT**

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.



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If any payment is made directly to you for services billed by us, you recognize an obligation to promptly pay Advanced Physical Therapy.

The above does not apply for those patients that are on an HMO/PPO plan or considered Workers' Compensation. However, be advised if you claim Workers' Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all the costs of collecting monies owed, including court costs, collections agency fees and attorney fees.

When you pay by check and your check is dishonored or returned for any reason, Advanced Physical Therapy adheres strictly to policy set forth for dishonored or returned checks by City of Anchorage District Attorney.

### **No Show and Cancellation Policy**

#### **NO SHOW:**

##### **Definition:**

A no show is defined as any patient that does not show to their scheduled appointment, and no phone call was given to cancel the appointment.

##### **Policy:**

A patient who no shows to 2 appointments in a row, is taken off the schedule for all remaining scheduled appointments. The patient remains a patient with Advanced Physical Therapy, however, and is welcome to make same day appointments. If the patient has a chronic no show history, 2 or more times (not consecutive) within 6 scheduled visits, the physical therapist and clinical director are advised of the problem and will meet to discuss the status of the patient.

#### **CANCELLATION:**

##### **Definition:**

A cancellation is defined as a same day call in to cancel the appointment.

##### **Policy:**

There is no charge for a cancelled appointment.

A patient who chronically cancels, is one who cancels appointments at a frequency of equal to or greater than 1 of every 3 scheduled appointments. In any given treatment period, cancellations for illness or unexpected emergencies can be expected. Chronic cancellation is equal to or greater than 4 cancellations within 12 scheduled visits.

**Signature of person completing this form** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_ **self** or \_\_\_\_\_ **Date** \_\_\_\_\_

**Advanced Physical Therapy Witness** \_\_\_\_\_ **Date** \_\_\_\_\_