

Function First Physical Therapy, P.C.
Patient Intake Form

Patient Information:

Last Name: _____			First Name: _____			Sex: _____								
Date of Birth: _____				SS#: _____-_____-_____										
Address: _____			City: _____			State: _____								
Zip Code: _____		Work#: () _____-_____		Home#: () _____-_____										
Email: _____				Mobile#: () _____-_____										
Marital Status: Single _____			Married _____			Divorced _____			Widowed _____			Domestic Partner _____		
Employer's Name: _____						Occupation: _____								
Physician's Name: _____						Diagnosis: _____								
Injury: Work or Auto related? _____						Allergies or Medical Precautions: _____								
Emergency Contact: _____						Phone#: () _____-_____								

Insurance Information:

Insurance Co. Name: _____				Policy#: _____			
Address: _____		City: _____		State: _____		Zip Code: _____	
Insured's Name: _____				SS#: _____-_____-_____		Date of Birth: _____	
Address: _____		City: _____		State: _____		Zip Code: _____	
Insured's Employer's Name: _____							

I hereby accept responsibility for the cost of this examination or treatment in the event that the Insurance Company denies this claim. I hereby understand and agree to accept responsibility of the cancellation policy of this office: Giving 24 hour notice to cancel: If I am unable to comply but reschedule the appointment before and within the end of the week, no charge will be made. Otherwise a \$45.00 fee will be charged for the missed session. (Please note that it is your responsibility - Insurance companies do not reimburse for missed appointments). Your co-operation is greatly appreciated.

Patient's signature: _____

Date Signed: _____

Function First Physical Therapy, P.C.
Patient Questionnaire/ History

Name: _____ Date of Birth: _____ Right or _____ Left handed

What is your Chief Complaint? _____

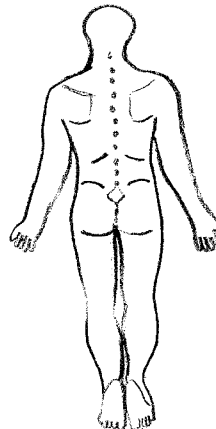
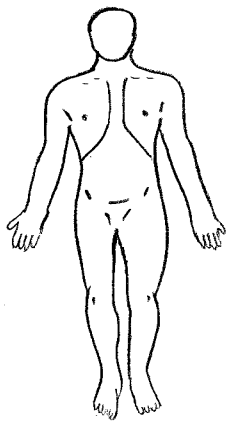
Rate your chief complaint in order of severity from worst (5) to least (1)

Pain ___ Decreased Motion ___ Swelling/edema ___ Stiffness ___ Loss of function _____

Where is your problem? Indicate on the body chart. Pain xxx: Numbness ooo: Tingling zzz:

Indicate the nature of your pain and symptoms: ___Sharp ___Dull ___Piercing ___Shooting ___Aching

___Deep ___Superficial ___Tingling ___Numbness ___Intermittent ___Burning ___Stabbing



When and how did this problem begin? _____

What makes your symptoms/ pain worse? _____

What makes your symptoms/ pain lessen? _____

Rate your pain on a visual scale (0-10) 0 no pain 10 excruciating pain: _____

Worst it has been _____ Past 2 to 4 weeks _____ Past 24 hours _____ At this moment _____

Are your symptoms worse in the: _____ Morning _____ Afternoon _____ Evening _____ Inconsistent _____

Are your symptoms: _____ Improving _____ Worse _____ Stable _____

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Medical History

Has this problem affected your daily life or routine? Briefly describe in what ways. _____

Have you had past similar episodes of this current problem? If yes, were you treated with (circle disciplines which apply); Physical Therapy, Acupuncture, M.D. (Meds, TPI's) Massage Therapist, Chiropractor, Pilates, General Exercise, Exercise with Trainer, Self Medicated (Advil), Ignored It, Other. Did they help to alleviate your symptoms? _____

Have you undergone any special tests for this condition? (X-rays, MRI's, ETC) If yes, do you know the results? _____

Please answer the following questions:

Yes No

1) Do the current problems interrupt your sleep?		
2) Do your symptoms change with coughing or sneezing?		
3) Have you had any recent changes in bowel or bladder function?		
4) Do you experience any dizziness or vertigo?		
5) Have you had any recent change in your weight or appetite?		
6) Do you have any intolerance to hot or cold?		
7) Do you have any bruising or bleeding disorders?		
8) Have you had any skin changes, such as rashes or discoloration?		
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
10) Have you had a recent episode of nausea/vomiting?		
11) Are you pregnant?		
12) Do you have osteoporosis? Date of your last bone scan:		
13) Do you have any allergies?		
14) Have you noticed any shortness of breath or decrease in exercise tolerance?		
15) Do you use any assistive devise? (cane foot orthotics)		
16) Do you have high blood pressure?		
17) Do you have any cardiac problems?		
18) Do you have diabetes?		
19) Have you ever had cancer of any sort?		
20) Do you have a history of neck or back problems?		

Any other illness, past injuries I should be aware of? _____

Past surgeries ___yes, ___no, give brief details: _____

List the medications you are currently taking (over the counter/prescription): _____

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Social History

Are you presently working? _____ Yes, _____ No, since: _____

Physical/Emotional demands of present occupation? (High, moderate, minimal) _____

Overall activity level: _____ Sedentary, _____ Light, _____ Moderate, _____ Heavy, _____ Very heavy.

Sports and Exercise (Type, Frequency, Duration) _____

Use of Tobacco _____ Yes, _____ No Use of Alcohol _____ Yes, _____ No

Family medical History:

Does any one in your immediate family (mother, father, siblings) have a history of Diabetes, High Blood Pressure, Cardiac Problems, or Cancer? _____

Please list 3 goals of Physical Therapy and time frames:

1) _____

2) _____

3) _____

Who can we thank for this referral? _____

Thank You for Your Patience and Valuable Time!!!

Function First Physical Therapy, P.C.
Billing Policy, Release, and Authorization

I authorize Function First Physical Therapy, P.C. to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Function First Physical Therapy, P.C. I authorize Function First Physical Therapy, P.C. to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatments. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

Signature: _____

Written Acknowledgement of Receipt of Notice of Privacy Practice

I, _____ hereby acknowledge that I have received a copy of The Notice of Privacy Practices.

Relationship to Patient (if patient is a minor): _____ *Date:* _____

Signature: _____

Cancellation Policy

The staff of Function First Physical Therapy is committed to improving its facilities and service provided to you. As a result, it has become necessary to implement a **\$45.00** late appointment cancellation fee for any scheduled appointments that are not cancelled within 24 hours, or for NO SHOWS.

Your cooperation is greatly appreciated. Thank you

I _____ have read and agree to the above terms and conditions.

Date Signed