MR #:
Patient Name:

FTG PHYSICAL THERAPY PATIENT DATA SHEET

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

Mailing Address:

Phone Numbers: **OK To Call** **Best Time To Call**

Home: ☐

Work: ☐

Cell: ☐

May we send you text messages for your appointment reminders to the number(s) listed above? ☐ Yes ☐ No

May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above? ☐ Yes ☐ No

By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email:

Preferred language: **Interpreter required?** ☐ Yes

Date of Injury: **Referring Physician:**

Injury Area: **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

State Where Accident Occured:

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: **Occupation:**

Address:

Phone:

Employer: **Occupation:**

Address:

Phone:

INSURANCE INFORMATION

Primary Insurance:

Policy Holder's Name: **Holder's Birth Date:**

Policy or Certificate #: **Group #:**

Policy Holder's Employer:

Secondary Insurance:

Policy Holder's Name: **Holder's Birth Date:**

Policy or Certificate #: **Group #:**

Policy Holder's Employer:

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other

Specify if other :

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

Name Relationship

Name Relationship

Signature of Patient

Date

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at: FTG PHYSICAL THERAPY In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature.

Initials: _____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

Initials: _____

LIABILITY

I know and agree that: FTG PHYSICAL THERAPY is not responsible for loss or damage to personal valuables.

Initials: _____

WAIVER AND RELEASE

I hereby release, discharge and acquit: FTG 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.

Initials: _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: FTG PHYSICAL THERAPY I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices.

Initials: _____

FINANCIAL POLICY

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.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.

Initials: _____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:** _____

I acknowledge receipt of the Statement of Patient Rights. **Initials:** _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ **Witness Signature** _____ **Date** _____

FTG PHYSICAL THERAPY

MEDICAL QUESTIONNAIRE

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

What is the reason for your visit today? _____

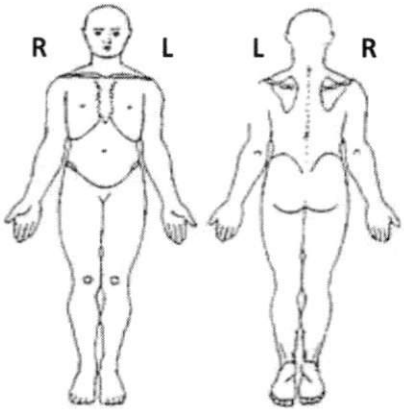
Employer: _____ **Occupation:** _____ **Hrs/Wk:** _____

Date of Injury: _____ **Date of Surgery (if applicable):** _____ **Side of Injury:** ❑ R ❑ L ❑ Bilateral

Where did your injury occur? ❑ Work ❑ Auto/MVA ❑ Home ❑ Gradual Onset ❑ Other: _____

Describe how your condition or injury occurred: _____

Briefly describe your symptoms: _____



Shade your areas of pain or discomfort on the figures to the left *(after printing document)*

Please rate your pain on the scale below from 0 to 10: (0 =no pain; 10 = worst pain imaginable)

Pain at rest: 0 1 2 3 4 5 6 7 8 9 10

Pain with activity: 0 1 2 3 4 5 6 7 8 9 10

What is the frequency of your pain? ❑ Constant ❑ Intermittent

Does your pain wake you at night? ❑ Y ❑ N **How many times?** _____

Are your symptoms getting: ❑ Better ❑ Worse ❑ Staying the same

When is your pain the worst: ❑ Morning ❑ Night ❑ Mid-Day

What eases your symptoms? _____

What aggravates your symptoms? _____

What activities at home, work or recreational are you unable to perform? _____

Have you had a similar condition before? ❑ Y ❑ N **If yes, when** _____

Have you had any of the following treatment and/or tests for this condition? (check all that apply)

❑ Physical Therapy ❑ Occupational Therapy ❑ Chiropractic ❑ Massage ❑ Hospitalization ❑ Home Health ❑ Acupuncture
❑ X-Rays ❑ MRI ❑ CT Scan ❑ Bone Scan ❑ Nerve Tests ❑ Bracing/Taping ❑ Other: _____

What do you hope to accomplish with Therapy? *(your personal goals)* _____

Medical History (Check all that apply)

❑ Allergies	❑ Chemical Dependency	❑ Fractures	❑ MRSA
List: _____	❑ Cancer	❑ Heart (Surgery, Attack, Disease)	❑ Multiple Sclerosis
❑ Anxiety	Type(s): _____	❑ Hepatitis	❑ Osteoporosis
❑ Asthma	❑ Depression	❑ High Blood Pressure	❑ Poor Circulation
❑ Arthritis	❑ Diabetes (Type I)	❑ High Cholesterol	❑ Seizures
❑ Blood Clots	❑ Diabetes (Type II)	❑ Hypoglycemia	❑ Sensitivity to heat/ice
❑ Bowel/Bladder Problems	❑ Dizziness/Vertigo	❑ Kidney Problems	❑ Stroke
❑ Bruise Easily	❑ Fibromyalgia	❑ Loss of balance/Falls	❑ Traumatic Injury

❑ Other: _____ ❑ No significant medical history

Other Relevant Medical Information

Height: _____ **Weight:** _____ **Do you have a pacemaker?** ❑ Y ❑ N **Do you have a latex allergy?** ❑ Y ❑ N

Do you smoke or chew tobacco: ❑ Y ❑ N **If yes, how much?** _____ **Are you pregnant?** ❑ Y ❑ N

How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you exercise outside of normal daily activities? ❑ Y ❑ N **Type and frequency of activities:** _____

List any surgeries/major accidents/illnesses with dates: _____

List current medications: _____

SIGNATURE: _____ **DATE:** _____

PROVIDER SIGNATURE: _____ DATE: _____