Physical Therapy Intake Form

Name: ______________________________________ Age: _______ Date:_____________________

Address: ____

Phone: ______________________________________ Email: ____

Would you like to receive appointment reminders via email? **Yes No**

Date of Birth: _______________ Gender: **Male Female** Relationship Status: **Single Married Widowed**

Occupation: ______________________________ Referring doctor: ____

Who should we thank for this referral? ____

Emergency contact

Name: _________________________ Phone #: _____________________ Relationship: __________________

Medical History

Have you ever had any of the following conditions?

- ☐ Cancer
- ☐ High Blood Pressure
- ☐ A-Fib/cardiac
- ☐ Pacemaker
- ☐ Osteoporosis/Osteopenia
- ☐ Orthopedic Surgery
- ☐ Allergies/Asthma
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Bladder/kidney disease
- ☐ Prostate disease
- ☐ Parkinson's Disease
- ☐ Osteoarthritis
- ☐ Lung Disease
- ☐ Kidney Disease
- ☐ Angina/Chest Pain
- ☐ Hearing Loss
- ☐ Vision Loss
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea/Insomnia
- ☐ Balance problems
- ☐ Depression
- ☐ Fatigue
- ☐ Vascular/Aneurysm
- ☐ Corticosteroid Use
- ☐ Headaches

Do you use tobacco? **Yes No** Did this injury happen in an accident? **Yes No**

How many falls have you had in the last year? **0 1 2 >2 None, but I often lose my balance and must catch myself**

Have you noticed any of the following in the last 3 months?

- ☐ Weight loss/Gain
- ☐ Nausea/Vomiting
- ☐ Night Pain
- ☐ Fever/Chills
- ☐ Numbness/Weakness
- ☐ Dizziness/lightheaded
- ☐ Changes in sexual function/sensation
- ☐ Changes in bowel or bladder function/retention
- ☐ Fever/chills/sweats
- ☐ Numbness/tingling
- ☐ Changes in sensation
- ☐ Changes in appetite
- ☐ Difficulty swallowing
- ☐ Change in steadiness/walking
- ☐ Shortness of breath
- ☐ Changes in strength
- ☐ Dropping items
- ☐ Dizziness
- ☐ Unusual headaches

Past Surgical History (list all & date): ____

____

During the past month, have you been bothered by feeling down, depressed, or hopeless? **YES NO**

During the past month, have you been bothered by little interest or pleasure in doing things? **YES NO**

Have you any of these tests/referrals for **this** condition? **XRay MRI CT Scan Blood Work Nerve Test Orthopedic Neurologist**

How are you able to sleep at night? **Fine Moderate Difficulty Only with Medication**

Tell us about your condition:

I am here to address my problem with____

How limited are you by this condition? **Not at all 0% - 20% - 40% - 60% - 80% - 100% Completely Limited**

When (approximately) did you present pain start? ____

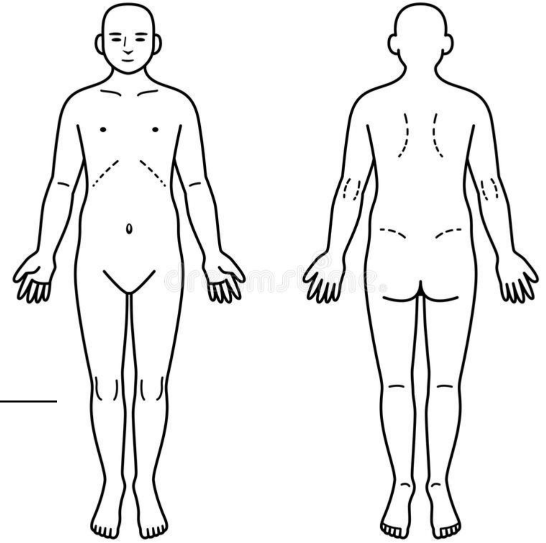
What caused this pain/problem and how did it come on (gradually, suddenly, injury)? _______________

Have you ever had this problem before? **Yes No** Did you seek treatment for complaint previously? ____________

With **0 being no pain** and **10 being worst pain imaginable**, please rate your pain for the following:

Average **for the last 48 hours: ____/10** ***Best*** **for the last 48 hours: ____/10** ***Worst*** **for the last 48 hours: ____/10**

What have you done for this condition? **Medicine Injection Surgery Exercise Stretching Rest Chiropractic**



Body Chart: Please indicate on the body where your symptoms are:
xx pain /// numbness ++ stiffness == tightness

My symptoms are currently: **Getting better About the same Getting worse**

What makes your symptoms better? ____

Please check the activities which make your pain worse:

□Lying down □Standing □Walking □Stress □Sitting □Other____________________

Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem.

1) ____

2) ____

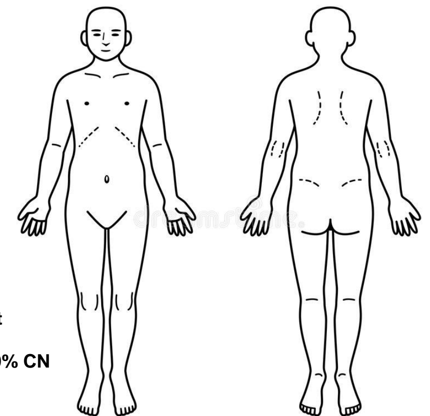
3) ____

What do you expect to accomplish with therapy? ____

I attest that this information is thorough and correct to the best of my knowledge

X __________________________________ **Date:** __________________________

For Clinician Use: **Freq/Dur Plan:**



24h – N/T toes/fingers/face – RA – Dizz – N/V – Ataxia – Severe HA – Bil/Quad/PeriOral Paresthesia – Anticoagulant
Drop Attacks- Diplopia – Dysarthria – Cough c Radicu pain – Steroid – Tobacco – Birth Control – High Cholesterol
HTN – Obesity – VBA / MI / CABG / DM 0% CH. 0-19% CI. 20-39% CJ 40-59% CK. 60-79% CL. 80-100% CM 100% CN
Oswestry NDI DHI. Q-DASH LEFS Tinetti TUG

BODY BALANCE LAKEWAY

TREATMENT AGREEMENT

CONSENT FOR CARE AND TREATMENT: I, the undersigned, hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Body Balance Lakeway. If patient is a minor under the age of 18, a parent or legal guardian must sign this agreement. I understand continuity of care will be provided to me by Physical Therapists and Physical Therapists Assistants. I agree and give my consent for Physical Therapy Services or Consult/Wellness to be provided by Body Balance Lakeway.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize insurance payment benefits to be paid directly to Body Balance Lakeway. I understand that insurance may not pay for all the services I receive and that I am responsible to pay for services or materials provided to me that are not paid by the insurance.

RELEASE OF INFORMATION: I authorize Body Balance Lakeway to release any information acquired in the course of my treatment to any person or entity which is or may be liable for all or any portion of the charges. A photocopy of this form shall be deemed as valid as the original.

CANCELLATION POLICY: Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least-24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of $100.00 for NO SHOW appointments or cancellations with less than 24-hour notification. I understand that I will be personally responsible for all charges regardless of the outcome from insurance companies, third-party payers, or any other payers.

FINANCIAL POLICY: I have read the Financial Policy for Body Balance Lakeway and accept that I am ultimately financially responsible for all charges regardless of the outcome from insurance companies, third-party payers, or any other payers.

NOTICE OF PRIVACY POLICIES: I have read the Notice of Health Information and Privacy Policies.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

Signature: _______________________________________ Date: _______________