A BODY IN MOTION STAYS IN MOTION

FLOW PHYSICAL THERAPY

PATIENT INFORMATION

Date _____

First Name _____ **Last Name** _____ **Middle** _____

Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Day Phone _____ **Home Phone** _____

Birth Date _____ **Email** _____

Marital Status Married ◉ Single ○ Other ○ **Sex** M ○ F ○ **Former Patient** Y ○ N ○

Other than your doctor, how did you hear about Flow Physical Therapy?

Former Patient:_____ Website:_____ Friend/Family:_____

Social Media:_____ Other:_____

Have you had therapy within the calendar year? Y ○ N ○ If yes, where?_____

Current Employment/School Information

Employer:_____ School:_____

Physician Information

Referring Physician _____ Phone Number _____

Address _____

If you would like us to send correspondence to your primary care physician, then please complete

Primary Care Physician _____ Phone Number _____

Address _____

Auto/3rd Party Auto Information

Is this an auto accident? Y ◯ N ◯ City, State, and Date of accident _____

Is this a lawsuit? Y ◯ N ◯ Law firm name _____

Attorney name _____ Phone _____

Insurance Information

Primary Insurance Company _____

Name of Policy Holder _____ Relationship _____

Date of Birth _____ ID# _____ Group# _____

Secondary Insurance Company _____

Name of Policy Holder _____ Relationship _____

Date of Birth _____ ID# _____ Group# _____

Have you verified your therapy benefits with your insurance company? Y ◯ N ◯

****You are strongly encouraged to verify your benefits****

Workers' Compensation

Employers Name _____ Employers Phone # _____

Employers Headquarters (city, state) _____

Job Title _____

Is this approved for Workers' Comp Injury? Y ◯ N ◯ Date of Injury _____

In what city and state were you injured? _____

Law firm name _____

Attorney name _____ Phone _____

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PATIENT MEDICAL HISTORY & INTAKE QUESTIONNAIRE

Name: _____ Age: _____

What problem(s) are you being treated for today? (Describe type and location of symptoms.)

_____

When and how did your present symptoms start?

_____

My symptoms are currently: ◯ **GETTING BETTER** ◯ **GETTING WORSE** ◯ **STAYING THE SAME**
My symptoms currently: ◯ **COME AND GO** ◉ **ARE CONSTANT** ◯ **CONSTANT, BUT CHANGE WITH ACTIVITY**

What makes you better? _____

What makes you worse? _____

Please rate your pain **Average** - 0 is no pain and 10 being the most painful.
1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯
Please rate the **Highest Intensity** of your pain over the last 24 hours.
1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯
Please rate the **Lowest Level** of your pain over the last 24 hours.
1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯
What time of day are your symptoms worse (circle one): ○ **MORNING** ○ **AFTERNOON** ○ **EVENING** ○ **OVERNIGHT**
Treatment received so far for this problem (circle all that apply):
☐ **Chiropractic** ☐ **Acupuncture** ☐ **Injections** ☐ **Physical/Occupational Therapy** **Other:**
Indicate special tests performed for this problem and results if known (circle all that apply):
☐ **X-ray** ☐ **Bone Scan** ☐ **CT Scan** ☐ **MRI** **Other**:

MEDICAL HISTORY

Have you recently noted any of the following (check all that apply):

- ☐ Change in bowel/bladder function
- ☐ Shortness of breath
- ☐ Nausea/vomiting
- ☐ Weakness/fatigue
- ☐ Headaches
- ☐ Dizziness/lightheadedness
- ☐ Difficulty maintaining balance while walking
- ☐ Difficulty swallowing
- ☐ Weight loss/gain
- ☐ Numbness/tingling
- ☐ Fever/chills/sweats
- ☐ Pain at night
- ☐ Changes in appetite

Please list past medical history (i.e., falls, pacemaker, surgeries) including dates (indicate if for current condition):

Please list allergies _____

Are you pregnant? ◯ NO ◯ YES If Yes, number of weeks: _____
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 having little interest/pleasure in doing things? ◯ YES ◯NO
Is this something with which you would like help? ◯ YES ◯ YES, BUT NOT TODAY ◯ NO

MEDICATIONS

Please provide names of all medications, vitamins, supplements, and over-the-counter drugs you are currently taking. We can copy a detailed list if you have one.

Medication Name	**How Taken**	**How Often**

SOCIAL HISTORY

Home: ◯ **House** ◯ **Condo/Apartment**
Do you live alone? ◯ **Yes** ◯ **No**
Occupation:
Are you currently working? ☐ **Light duty** ☐ **Full Duty** ☐ **Not Working** **If not working, date last worked**:

Leisure Activities/Hobbies/Exercise Routine:

_____

What activities comprise your day? (circle all that apply): ☐**Sitting** ☐**Standing** ☐**Walking** ☐**Lifting** **Other:**
Do you use tobacco? ◯**YES** ◯**NO**
Alcohol intake and frequency: _____

Is there anything else we should know that is pertinent to your treatment?

_____

What is your goal for therapy? _____

Date of next physician appointment: _____

The above information I have supplied is complete, true, and correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Consent and Statement of Financial Responsibility

1. **Consent for Treatment**: I consent to and authorize my physical therapist and other healthcare professionals and assistants who may be involved in my care to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge no guarantees have been made to me about the results of treatment.
2. **Appointment Attendance Agreement**: I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24–hours' notice when I need to cancel or reschedule an appointment. Any cancellation of less than 24 hours or not showing up for an appointment will result in a cancelation fee of $30 or $60 depending on appointment type.

   Workerss Compensation Patients: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Workers' Compensation Adjuster and/or Rehabilitation Manager of all missed or cancelled appointments. We also require you to reschedule all missed appointments.

3. **Responsibility for Payment**: All co-payments are due at the time of service. I acknowledge in consideration for the services provided to me by Flow Physical Therapy, I am financially responsible for payment of my bill. I acknowledge it is my responsibility to provide Flow Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my insurance provider. My health insurance may provide a portion of the charges and balance remain my personal responsibility such as: deductibles, co-payments, co-insurance, or other charges not covered or otherwise denied by my health insurance, Medicare, or other programs for which I may be eligible.
4. **Assignment of Benefits**: I hereby assign to Flow Physical Therapy all my rights and claims of reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.
5. **Access to and Release of Health Information**: I understand Flow Physical Therapy may document medical and other information related to my treatment in electronic and other forms and such information will be used in the course of my treatment for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Flow Physical Therapy's staff to contact other healthcare professionals who may have information related to my prior and current health conditions and treatment. I acknowledge I have received Flow Physical Therapy's Notice of Privacy Practices and it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.
6. **HIPAA Consents**: In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account:

   Name/Relationship: _____

   I also authorize the release of appointment information left in a voicemail, answering machine, or text message and understand there is a level of privacy risk associated with these forms of communication.

7. **Consent for Emergency Contact Information**:
   Person to contact in case of emergency:

   Name: _____ Telephone Number: _____ Relationship: _____

   By my signature below, I certify I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

   Signature of patient or legally responsible person: _____ Date: _____

   Printed name of above: _____ Date: _____

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