Attachment B1.003A
Attachment M7.005C

PATIENT INTAKE AND CONSENT FORM

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

First Name _____ MI _____ Date of Injury/Onset _____ Today's Date _____

Last Name _____ Date of Birth _____ Age _____

Address _____ Sex ☐M ☐F Marital Status ☐S ☐M ☐D ☐W

_____ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Cell Phone _____

Responsible Party _____ E-mail _____

Address _____ Injury Area _____

City _____ Accident Related: ☐Yes ☐No

Phone Number _____ If Accident: ☐Auto ☐Work ☐Other

Relationship to Responsible Party _____ Nature of Accident _____

SS# _____

Employer _____

Address _____ Occupation _____

City _____ State _____ Zip _____ Contact at Employer _____

Referring Physician _____ Phone Number _____

Primary Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: ☐M ☐F

Second Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: ☐M ☐F

Emergency Contact _____ Daytime Phone Number _____

Are you receiving or have you received home health services? ☐Yes ☐No

Are you receiving or have you received other therapy services? ☐Yes ☐No

(Continued on next page)

PATIENT INTAKE AND CONSENT FORM

Please Initial Each as Applicable:

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

CONSENT TO TREATMENT: I consent to rehabilitation and related services at Fredericksburg Physical Therapy. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of sensitive nature. _____

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. _____

LIABILITY: I know and agree that Fredericksburg Physical Therapy is not responsible for loss or damage to personal valuables. _____

WAIVER AND RELEASE: I hereby release, discharge and acquit Fredericksburg Physical Therapy, it's 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. _____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment. _____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. _____

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

Patient/Guardian Signature_____ Witness Signature_____

 This form must be completed in its entirety and must be provided to Fredericksburg Physical Therapy prior to initiation of therapy services.

FREDERICKSBURG PHYSICAL THERAPY MEDICAL HISTORY FORM

PATIENT NAME: _____ **TODAY'S DATE:** _____

REFERRING PHYSICIAN'S NAME: _____ **DATE OF INJURY OR ONSET:** _____

CAUSE OF INJURY OR ONSET: _____ **ARE YOU PRESENTLY WORKING? Y N**

PRIMARY CARE PHYSICIAN'S NAME: _____ **DATE OF NEXT MD APPT:** _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR
DO YOU USE TOBACCO? (circle one) YES NO IF YES, HOW MUCH? _____

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN_____ **AND WHY**_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE / WHAT WERE THE RESULTS:
_____

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: _____

_____

ALLERGIES: Medication _____**Reaction**_____**Medication**_____**Reaction**_____

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction_____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction_____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

□ ANEMIA
□ ARTHRITIS
□ CANCER
□ CARDIOVASCULAR PROBLEMS
□ HOLTER MONITOR - currently wearing?
  □ PACEMAKER
  □ HIGH BLOOD PRESSURE □ controlled □ uncontrolled
□ LOW BLOOD PRESSURE
□ CURRENTLY PREGNANT
□ DIABETES □controlled □uncontrolled
□ DEPRESSION
□ DIZZINESS/FAINTING
□ FRACTURES
□ HEADACHES
□ HEPATITIS/HIV
□ KIDNEY PROBLEMS
□ MRSA (Methicillin Resistant Staphylococcus Aureus)
□ OSTEOPOROSIS
□ RESPIRATORY PROBLEMS
  □ ASTHMA □ controlled □ uncontrolled
  □ COPD □ controlled □ uncontrolled
  □ Other
□ SEIZURES □ controlled □ uncontrolled
□ THYROID PROBLEMS

If checked any above, explain: _____

_____

□ ANY OTHER MEDICAL PROBLEMS: _____

_____

SIGNATURE OF PATIENT: _____ **REVIEWED BY Therapist:** _____**Date**_____

 Revised 06.02.2010kb