PHOENIX
PHYSICAL THERAPY

INTAKE FORM

IS THIS A WC CASE? ☐ **IS THIS A MVA CASE?** ☐ **DO YOU HAVE AN ATTORNEY?** ☐

Last Name _____ MI _____ First Name _____ DOB _____ ☐ Female ☐ Male

Street _____ Apt _____ City/State _____ Zip _____

SSN _____ Home telephone _____ Cell number _____ ☐ Check here if ***NOT*** ok to contact you by phone or email

Referral Physician _____ Telephone Number _____

Who may we thank for referring you? _____ ☐ MD ☐ Yellow pages ☐ Friend/Family ☐ Ad

Your Email Address _____ Reason for visit _____ Date of onset/injury _____ ☐ Single ☐ Married ☐ Widow ☐ Divorced

Employer _____ Address _____ City/State Zip _____ Telephone Number _____

Employed: ☐ PT/FT ☐ Unemployed ☐ Student ☐ Retired Surgical Procedure _____ Date _____

EMERGENCY CONTACT: _____ Relationship to patient _____ Telephone Number _____

Name of Responsible Party _____ ☐ Self ☐ Spouse ☐ Parent ☐ Other

INSURANCE INFORMATION

SUBSCRIBER for PRIMARY Insurance Plan: ☐ Self ☐ Spouse ☐ Parent ☐ Other Name _____

SSN _____ DOB _____ PRIMARY Insurance Company _____ ID# _____ Group# _____

PRIMARY Insurance company address _____ Telephone Number _____

SUBSCRIBER FOR SECONDARY ☐ Self ☐ Spouse ☐ Parent ☐ Other Name _____

SSN _____ DOB _____ SECONDARY Insurance Company _____ ID# _____ Group# _____

SECONDARY Insurance company address _____ Telephone Number _____

Patient's Signature _____ Date _____ (First visit signature)

PLEASE DO NOT SIGN THIS LINE UPON INITIAL VISIT. _____ Date _____ (Second year verification)

PLEASE DO NOT SIGN THIS LINE UPON INITIAL VISIT _____ Date _____ (Third year verification)

I hereby assign all insurance benefits payable to Phoenix Physical Therapy for all services rendered to me. I authorize Phoenix Physical Therapy to provide treatment rendered to me as prescribed by my referring physician. I authorize the release of medical records towards reimbursement of my services. I understand that my bill for services rendered to me by Phoenix Physical Therapy is my total responsibility if insurance or motor vehicle accident insurance does not accept responsibility. I agree and understand that any copays, deductibles and co-insurances are my direct responsibility. COPAYS ARE DUE ON DATE OF SERVICE

Patient and/or responsibility party's signature _____ Date _____ (HIPAA FORM SIGNED Y N STAFF INITIALS _____)

Edited 12/30/13

PATIENT HISTORY

NAME: _____ DATE OF NEXT MD APPOINTMENT: _____

Describe briefly the history of your present ACCIDENT, INJURY, ILLNESS OR CONDITION:
Onset Date: _____ Description: _____

_____

_____

Please list any special concerns, questions or expectations:_____

_____

Have you fallen in the past year? _____ If so, how many times? _____ If so, did you sustain an injury?
_____

Have you had <u>any physical therapy</u> during the current calendar year? _____ Have you had physical therapy for the same condition for which you are here today? _____ If yes, please indicate where and when:

_____

List **<u>ALL</u>** medications you are currently taking:_____

_ _____

_____

Please list recent diagnostic studies (CAT scan, MRI, X-ray, ETC.) & where taken: _____

_____

Do you have METAL anywhere in your body (other than teeth), such as pins/plates, pacemaker, stints, etc.?
Describe _____

Please list **<u>ALL</u>** surgeries you have had; please give procedures and dates, if possible: _____

_____

_____

Have you ever had: (Please circle yes or no)

High blood pressure	Yes	No	Arthritis/Osteoarthritis	Yes	No
Heart disorders	Yes	No	Osteoporosis	Yes	No
High Cholesterol	Yes	No	Cancer	Yes	No
Lung Disorders	Yes	No	Pacemaker	Yes	No
Circulation disorders	Yes	No	Are you pregnant?	Yes	No
Dizzy Spells	Yes	No	Allergies to tapes or lotions?	Yes	No
Seizures	Yes	No	Tobacco use	Yes	No
Diabetes	Yes	No			

_____

_____

SIGNATURE: _____ DATE:_____