STRATTON PHYSIO 10 Arbor Rd Stratton, VT 05360 Phone 802-867-7056 Fax 802-440-0280

PATIENT HEALTH HISTORY & INTAKE FORM

Name_____ **D.O.B.** _____ **DATE:** _____

Gender: _____ **Preferred Pronoun: She/her/hers He/him/his They/them/theirs**

MAILING ADDRESS (required): _____

PHYSICAL ADDRESS (IF DIFFERENT FROM MAILING**):** _____

PHONE (*one required*) *(CELL)* _____ **(HOME)** _____ **(WORK)**_____

EMAIL ADDRESS: (*required*) _____

PREFERRED CONTACT METHOD (CIRCLE ALL OR ONE): EMAIL, VOICE, OR TEXT

EMERGENCY CONTACT: _____ ***(PHONE)*** _____ ***(RELATIONSHIP)*** _____

SURGERY/ INJURY DATE: _____ **DIAGNOSIS (IF HAVE ONE):** _____ **L or R (circle)**

REFERRING DOCTOR NAME (FIRST, LAST): _____

REFERRING DOCTOR PHONE:_____ ***(CITY, STATE)*** _____

PRIMARY CARE PHYSICIAN NAME (FIRST, LAST):_____

PRIMARY CARE PHONE:_____ ***(CITY, STATE)*** _____

HOW DID YOU HEAR ABOUT US? IF A FRIEND, PLEASE TELL US WHO SO WE MAY THANK THEM

_____

PRIMARY INSURANCE INFORMATION:

INSURANCE CARRIER: _____ INSURANCE PHONE NUMBER: _____
SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____
SUBSCRIBER ID#: _____. GROUP #:_____
RELATION TO SUBSCRIBER: _____

SECONDARY INSURANCE INFORMATION (REQUIRED FOR MEDICARE PATIENTS*)

INSURANCE CARRIER: _____ INSURANCE PHONE NUMBER: _____
SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____
SUBSCRIBER ID#: _____. GROUP #:_____
RELATION TO SUBSCRIBER: _____

*****MEDICARE PATIENTS REQUIRE A PART B PLAN FOR OUTPATIENT PHYSICAL THERAPY HERE AT DORSET PHYSIO. IF YOU ARE A MEDICARE PATIENT AND DO NOT HAVE A SECONDARY PLAN, PLEASE SPEAK WITH OUR PATIENT COORDINATOR PRIOR TO YOUR APPOINTMENT.*

WORKERS COMP PATIENTS ONLY:

SS # ___ ___ ___ / ___ ___ / __ __ __ (SS# required for WC claims) DATE OF INJURY:_____
LIGHT DUTY OR FULL DUTY: _____ OUT OF WORK SINCE: _____
EMPLOYER: _____ EMPLOYER ADDRESS: _____
WC INSURANCE COMPANY: _____ ADDRESS _____
TELEPHONE # _____ CASE MANAGER NAME _____ CLAIM # _____

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Name_____ **D.O.B.** _____ **DATE:** _____

Chief Complaint: What is the nature of your pain or problem? _____
_____
_____

Have you seen any other health professional(s) for this condition? YES NO If yes, who? _____
Have you ever been to PT? ***(circle)*** **YES NO If so, how many times this year?** _____
Are you currently receiving any HOME HEALTH CARE? YES NO End Date: _____
Injury work related? ***(circle)*** **YES NO Employer**_____
Injury motor vehicle related? ***(circle)*** **YES NO If yes, are you currently working with an Attorney? YES NO**
Name, Address, and Phone Number of Attorney_____

Please list all Medications, Vitamins/Supplements (we are happy to make a photocopy of your list at your appointment):
_____
_____

Do you use any drugs or alcohol? Y N What and how frequent?_____

Do you smoke or vape? Y N If year, what type and how many years? _____

Are you allergic to LATEX? Y N Any other Allergies? _____

Do you now have, or have you had, any of the following?

Heart Disease/Attack	**YES NO**	**Diabetes**	**YES NO**
Cancer	**YES NO**	**Seizures**	**YES NO**
Pregnant (currently)	**YES NO**	**High Blood Pressure**	**YES NO**
Dizziness	**YES NO**	**Osteoporosis**	**YES NO**
Stroke	**YES NO**	**Asthma/COPD**	**YES NO**
Chronic Headaches	**YES NO**	**Arthritis/Joint Pain**	**YES NO**
Tooth/Jaw/Ear Pain	**YES NO**	**Previous Physical Therapy**	**YES NO**
Past Surgeries	**YES NO**	**Anxiety/Depression**	**YES NO**

Have you had any of the following? ▢**MRI** ▢ **X-Ray** ▢**CT Scan If yes, where?** _____
If you answered YES to any of the above or any other medical history you wish to share with your provider that can affect your treatment, please explain and give approximate dates and/or details:

_____
_____

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Name_____ **D.O.B.** _____ **DATE:** _____

PAIN DIAGRAM

Please indicate on the pictures to the right the locations of your pain. *(if applicable)*

Please indicate your level of pain at its WORST and BEST on the left.

0=NO PAIN 10=EXCRUCIATING PAIN

CURRENT: 0 1 2 3 4 5 6 7 8 9 10

BEST: 0 1 2 3 4 5 6 7 8 9 10

WORST: 0 1 2 3 4 5 6 7 8 9 10

TIME OF DAY PAIN IS WORSE (circle one):

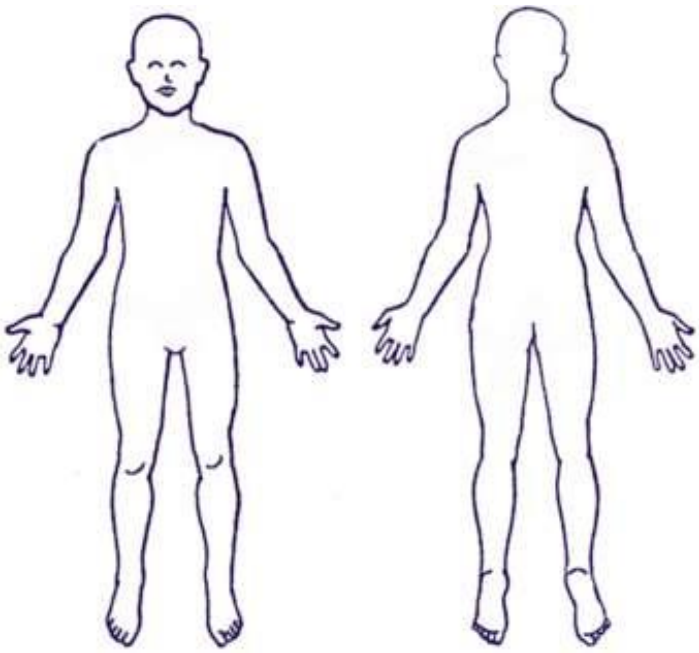
MORNING AFTERNOON NIGHT

INTERMITTENT CONSTANT

TIME OF DAY PAIN IS BEST (circle one):

MORNING AFTERNOON NIGHT

INTERMITTENT CONSTANT



Do you use any Assistive Device/Equipment (circle all that apply): Cane Walker Crutches Walking Poles Wheelchair Brace/Splint Lift Chair Shower Chair Bedside Commode

If you are 65 and over OR have sustained a fall please answer these questions:
Have you had any falls in the past 6 months?*(circle one)* **YES NO How many:**_____
Any fall(s) that resulted in injury?*(circle one)* **YES NO**
If answered YES to any fall or injury from a fall, please describe here:
_____

Please List 3 goals you have for Physical Therapy:

1. _____
2. _____
3. _____

The information above is accurate to the best of my knowledge.

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Patient Signature: _____ Date: _____

STRATTON PHYSIO PHYSICAL THERAPY PLC CONSENT & RELEASE FORM

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY POLICY

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

MEDICALLY INFORMED CONSENT

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of services at Dorset Physio Physical Therapy. It is the clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. This consent shall be ongoing for a period not to exceed one year. I (*print name*) _____ have read this form and fully understand and accept its terms and conditions.

PATIENT RESPONSIBILITY

I acknowledge that it is my responsibility to understand the coverage and limits of my insurance policy. I understand that I am responsible for co-payments, deductibles, and/or patient balances as directed by my insurance policy. In the event that my insurance denies payment I understand that I am responsible for my bill. If you are currently receiving home health care you cannot be seen by Dorset Physio Physical Therapy at the same time. In the case this happens, and the insurance denies, you will be responsible for the bill. I understand that if I have questions about my bill, I may speak with Kelly Gaiotti, DPT owner about my bill. My therapist is not responsible for knowing, giving advice about or reviewing my coverage.

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid directly to Dorset Physio Physical Therapy and understand that I am financially responsible for non-covered services. I understand that if Dorset Physio Physical Therapy does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays. I also authorize the physician and/or Dorset Physio Physical Therapy to release any information necessary in order to process any and all claims. All of the information provided is correct and true to the best of my knowledge.

NO SHOW/CANCELLATION POLICY

In addition, I understand and agree with Dorset Physio Physical Therapy's "no-show," / cancellation / rescheduling policy: I will be charged a $50.00 fee in the event that I miss an appointment, cancel and / or reschedule in less than a 24-hour period. Step Down Program Clients will be charged for a full session.

Signed: _____ Date: _____
Print Name: _____
If not signed by the patient, please indicate relationship: _____
Name of patient: _____

For office use only: Signed form received by: _____

HIPAA Acknowledgment refused: Y N Efforts to obtain: Y N Reason for refusal: _____