



## PATIENT INTAKE FORM

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF ONSET OF SYMPTOMS/INJURY: \_\_\_\_\_ DATE OF SURGERY (if applicable): \_\_\_\_\_

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) \_\_\_\_\_

REFERRING PROVIDER OR NO REFERRAL? \_\_\_\_\_

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 OR AUTO 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 # \_\_\_\_\_



## PATIENT HEALTH HISTORY FORM

Name \_\_\_\_\_ Age \_\_\_\_\_ D.O.B. \_\_\_\_\_

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

Date of Injury/Onset of Pain \_\_\_\_\_ Date of Surgery (if applicable): \_\_\_\_\_

Referring Physician \_\_\_\_\_ Next appointment with referring physician \_\_\_\_\_

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 here** (or we are happy to make a photocopy of your list at your appointment):

\_\_\_\_\_

Are you allergic to LATEX? YES NO 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:

\_\_\_\_\_



### 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):

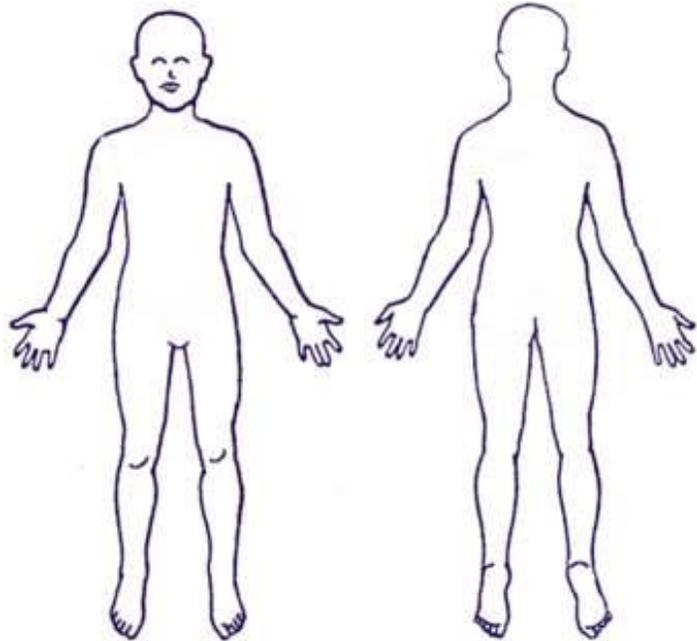
MORNING AFTERNOON NIGHT

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:

\_\_\_\_\_

Is there anything else you feel we should know to assist in your treatment?

\_\_\_\_\_

Please List 3 goals you have for Physical Therapy:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## DORSET 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: \_\_\_\_\_