WALKER
PHYSICAL THERAPY
& SPORTS INJURY CENTER

PATIENT INTAKE FORM- PPO/HMO/MEDICARE/SELF PAY

First Name: _____ Middle Initial: _____ Last Name: _____

Nickname: _____ Date of Birth: _____ / _____ / _____ SSN: _____

☐ Male ☐ Female Age:_____ Home Phone: _____ Cell: _____

Residence Address: _____

Mailing Address (if different): _____

Emergency Contact: _____ Phone: _____ Relationship: _____

May we add you to our E- Newsletter? ☐ Yes ☐ No Email Address: _____

Would you like appointment reminders by text message? ☐ Yes ☐ No

Would you like appointment reminders by automatic phone call? ☐ Yes ☐ No

Primary Insurance

Insurance Company: _____

Name of Subscriber: _____ Date of Birth: _____ /_____ /_____

Relationship to Patient: _____ Phone: _____ SSN: _____ - _____ - _____

ID #: _____ Group #/Name:_____

Is this injury work or auto related? ☐ Yes ☐ No Is there an attorney involved? ☐ Yes ☐ No

Date of Injury: ____ / ____ / _____ Claim #: _____

If any of the above questions were marked "YES", please speak with the front desk to ensure proper billing.

Secondary Insurance ***If you have NO secondary insurance, initial here (_____)***

Insurance Company: _____

Name of Subscriber: _____ Date of Birth: _____ /_____ /_____

Relationship to Patient: _____ Phone: _____ SSN: _____ - _____ - _____

ID #: _____ Group #/Name:_____

Financial Policy

I, undersigned have insurance coverage and assign directly to Walker Physical Therapy, Inc. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance including any amounts due at the time of service. I hereby authorize the medical provider to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions.

Signature: _____ Date: _____ Relationship: _____

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MEDICAL INTAKE FORM

Thank you for choosing Walker Physical Therapy and Sport Injury Center.
Please take your time while answering the following questions as it will help us give you the best care possible.

PATIENT HISTORY

Patient Name: _____ Age: _____ Diagnosis: _____

Referring Physician: _____ Recent Surgery and Dates: _____

Medications: 1. _____ Dosage: _____ Frequency: _____

2. _____ Dosage: _____ Frequency: _____

3. _____ Dosage: _____ Frequency: _____

4. _____ Dosage: _____ Frequency: _____

Other Medications/Vitamins: _____

CURRENT CONDITION

Date of injury: _____ Mechanism of injury: _____

Describe your chief complaint / concern: _____

_____

Identify any position / activity that eases your symptoms: _____

_____

Identify any position / activity that aggravates your symptoms: _____

_____

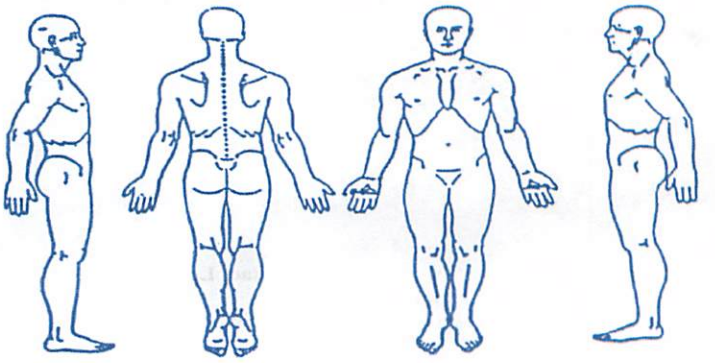
What is your goal with physical therapy: _____

_____

BODY CHART / PAIN LEVEL

Mark areas where you feel symptoms. Use the symbols to describe your symptoms and rate the pain 0-10 with 0 as no pain and 10 as so intense you would need to go to the emergency room.

T = Tingling
N = Numbness
P = Pain
S = Shooting / Sharp pain



Do your symptoms (check one:)
o Come and go o Constant o Change with activity

Does your pain / symptoms subside while resting at night? o Yes o No

CURRENT SYMPTOMS / CONDITION

(check all that apply)

o Cancer / infection o Fever, chills, night sweats o Nausea / vomiting o Unexplained weakness / pain	o Recent falls o Balance / dizziness o Weakness / joint pain o Numbness / tingling	o Abdominal pain / pulsating o Blood in urine o Changes in bowel / bladder o Difficulty swallowing
o Pregnancy o Smoker o Confusion / memory loss o Pacemaker	o Shortness of breath o Excessive cough o Severe pain in calf o High blood pressure	o Diabetes o Excessive thirst o Insulin dependent Injection time _____

During the past month, have you been feeling down, depressed, or hopeless? o Yes o No

During the past month, have you been bothered by having little interest or pleasure in doing things? o Yes o No

If yes to either question above, is this something you would like help with? o Yes o No

PAST MEDICAL HISTORY

List any medical condition you have been diagnosed with or hospitalized for:

_____

_____

_____

_____

_____

Patient / guardian signature: _____ Date: _____

Physical Therapist Use Only

(notes for follow-up questions)

_____

_____

_____

_____

_____

_____

_____

_____

BP _____ Falls efficacy scale _____ Tug _____ SLS (R) _____ (L) _____

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NOTICE OF PRIVACY

PATIENTS PROTECTED HEALTH INFORMATION

This notice describes how health care information, about you, may be used, disclosed and how you can get access to this information. Please review carefully. This office abides by the terms described in this policy.

I. This office uses and discloses your protected health information for the following reasons*:

1. To share with other treating health care providers regarding your health care
2. To submit to insurance companies or workers compensation claims to verify that treatment has been rendered
3. To determine patient's benefits in a health care plan
4. Releasing information required by state or federal public health law
5. To assist in overcoming a language barrier when caring for a patient
6. To provide written assurances to business associates that your privacy has been attained/maintained
7. Emergency situations
8. Abuse, neglect or domestic violence
9. Appointment reminders to household members or answering machines
10. Sign-in logs may be disclosed to verify office visits

II. You have the right to:

1. Revoke authorization, in writing, at any time by specifying what you want restricted, and to whom
2. Speak to our staff regarding privacy issues. Our privacy officer can be reached at the number listed below.
3. Inspect, copy and amend your protected health information and amend it *as allowed by law*
4. Obtain an accounting of disclosures of your protected health information
5. To render a complaint to our privacy officer or the Secretary of Health and Human Services

** Any other uses or disclosures will only be made with your specific, written prior authorization or as indicated below.*

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy, upon request, at any time from the staff at Walker Physical Therapy, Inc.

I hereby authorize information to be released only to the following person(s) listed below:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

I acknowledge that I have received and reviewed this notice with full understanding as indicated by my own or my legal representative's signature below:

Print Patient's Name _____ Signature of Patient/Legal Representative _____ Date Signed _____

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