

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

### Patient History Intake Form

1. Please describe the problem that brings you here, along with how and when it happened.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Please check whether this problem is  Chronic (meaning persisting for a long time or constantly recurring) or  Acute (meaning a rapid onset and occurred recently.)

3. Date of Injury: \_\_\_\_\_ Please be specific as possible. Approximant Time: \_\_\_\_\_

4. Date of Surgery, if any: \_\_\_\_\_

5. What makes the problem feel worse? \_\_\_\_\_

6. What makes the problem feel better? \_\_\_\_\_

7. What treatment have you had for this problem?

(X-Ray, MRI, Injections, Medications, acupuncture, chiropractic, ect.)

8. Date and location of last imaging test?

9. Current medications and supplements:

\_\_\_\_\_  
\_\_\_\_\_

10. Does the discomfort disturb your work? Circle one: Yes/No If yes, please describe how: \_\_\_\_\_

11. Does the discomfort disturb your sleep? Circle one: Yes/No If yes, please describe how: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

12. On a scale of 1-10 with 10 being the worst pain, please rate the pain level you have today /10

13. How would you describe the symptoms that you are experiencing? Circle all that apply

Numbness

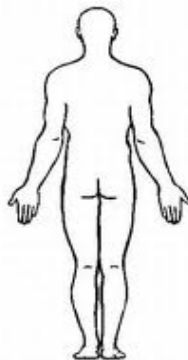
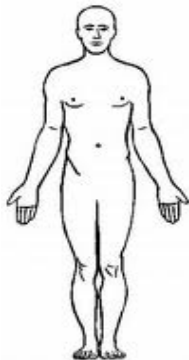
Pins & Needles

Burning

Stabbing

Aching

14. On the drawing below, please indicate the painful areas on your body that we will be treating by circling them



15. Do you have any of the following conditions? Circle all that apply

- High blood pressure
- Heart problems
- Vascular problems
- Back problems
- Kidney problems
- COPD
- Previous accidents
- Diabetes
- Stroke

- Cancer
- Seizures
- Metal implants
- Osteoporosis
- Anxiety
- Depression
- Chronic headaches
- Neurological disease
- Arthritis
- Allergies/Asthma
- Allergies to heat or ice

16. Are you currently or could you be pregnant? Yes/No

17. Please describe your occupation and activities at home:

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### Patient Guidelines

- In order to receive maximum benefit from your rehabilitation program, you must attend your therapy appointments and follow your home program.
- Cancellations within less than a full 24 hour notice are subject to a **\$35.00 fee** x \_\_\_\_\_
- Attention: Patients with workers compensation cases- If you cancel within less than 24 hour notice or no show an appointment, we will contact your Doctor's office and adjuster to make them aware.
- No Showing an appointment means that you do not call or you call right before a scheduled appointment to cancel.
- It is your responsibility to inform our staff of any Physicians appointments
- Yu are subject to being discharged from our practice after 3 missed appointments.
- We do bill your primary and secondary insurances as a courtesy. We do NOT bill tertiary.
- We do collect copayments, coinsurances and deductibles AT the time of visit.
- Please note, that as a courtesy, we do verify your eligibility and benefits prior to your first appointment. However, this is an estimate and not a guarantee of coverage.
- If we are not "in-network" with your insurance carrier, benefits can be different. It is your responsibility to verify this prior to your appointment.

Direct Access or Assembly Bill 1000 took effect on January 01 2014. The Bill expands patient access to Physical Therapy services for immediate treatment for up to 45 days or 12 visits, whichever comes first. This means that people with no insurance do not require a referral for 45 days/12 visits and most insurance carriers are not requiring a referral either. However, some carriers still require a referral and we are required by state law to follow those guidelines. If you have questions regarding this Bill, Please feel free to ask on of our front desk staff.

I UNDERSTAND AND CONSENT TO THE TREATMENT THAT WILL BE RENDERED BY BAY PHYSICAL THERAPY AND FITNESS CENTER.

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Signature

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## Patient Demographic Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ Issue State: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: (            ) -            -            Cell Phone: (            ) -            -

Referring Doctor Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Number: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I hereby authorize my insurance carrier to directly pay Bay Physical Therapy for all professional and medical services rendered to me. This is a direct assignment of my rights and benefits under my policy. I agree to pay in a timely manner and understand all copayments, coinsurances, and deductibles will be collected at the time of service. If I cancel within less than 24 hours or "no show"( Meaning do not call to cancel or come in to keep appointment I fully understand I will be charged a \$35.00 fee, payable before making any subsequent appointments. A photocopy of this shall be considered valid and effective. I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in my case. I agree that regardless of my insurance status, I am responsible for any unpaid balance on my account for services rendered. I certify that this information is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature Date

If under 18: \_\_\_\_\_  
Guardian name and signature Date