Patient Intake Form

Amy Hill Physical Therapy & Pilates P.C. (720-502-3022)

Patient Information

Name: _____ MI: ___ DOB: _____ Age: _____ Gender: __

Preferred Email: _____ Social Security Number: _____

Preferred Phone: _____ Secondary Phone (if applicable): _____

Address: _____ City: _____ State: ___ Zip: _____

Home Status/Functional Level:

Lives With: ◯ Alone / ◯ Spouse/Partner / ◯ Family / ◯ Friends / ◯ Other

Home: ◯ 1 story / ◯ 2 Story / ◯ Apartment / ◯ Mobile Home / ◯ Other

How many sets of stairs do you have? _____ Are there handrails: ◯Yes ◯No

Do you?: ◯ Smoke? How much___ / ◯ Drink Alcohol? How much___

Emergency Contact: _____ Relation to Patient: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone Number: _____ Secondary Method of Contact _____

Employer Name: _____ Employer Phone: _____

This Section is for Medical Record Compliance - if you want to opt out check here ◯
Primary Language: ◯ English / ◯ Spanish / ◯ ASL / ◯ French / ◯ Japanese / ◯ Dutch
Race: ◯ Native American or Alaskan Native / ◯ Asian / ◯ Black / ◯ Native Hawaiian or Other Pacific Islander / ◯ White
Ethnicity: ◯ Hispanic or Latino / ◯ Not Hispanic or Latino

Insurance Information

Primary Insurance:

Insurance Company: _____ Plan Name: _____

Subscriber ID: _____ Group Number: _____ Visit Co-Pay:_____

Primary Insured(PolicyHolder): _____ Primary DOB: _____

Primary SSN: _____ Patient Relationship to Primary: _____

Secondary Insurance:

Insurance Company: _____ Plan Name: _____

Subscriber ID: _____ Group Number: _____ Visit Co-Pay:_____

Primary Insured(PolicyHolder): _____ Primary DOB: _____

Primary SSN: _____ Patient Relationship to Primary: _____

Financially Responsible: (Only if the person responsible for the bill is not the patient)

Name: _____ DOB: _____ SSN: _____
Relationship to patient:_____
Signature: _____ Today's Date: _____

Injury Information

Background

Date of injury: _____ Affected Area: _____ Referred by: _____

Why are you seeking therapy? _____

_____

How did your injury start?: _____

What makes symptoms worse?: _____

Have you had previous therapy for this injury?: ◯ Yes ◯ No

If yes, how many visits?_____ When was your last visit?_____

What kinds of treatment have you received for this injury?

◯ None ◯ Medication ◯ PT/OT ◯ Chiropractic	◯ Massage ◯ Exercise ◯ Injections ◯ Acupuncture	◯ TENS Unit ◯ Traction ◯ Surgery ◯ Splinting/Taping	◯ Bracing ◯ Pain Clinic ◯ Other _____

List any surgeries associated with the condition?: _____

Do you have any assistive equipment? Check all which apply: ◯ Crutches / ◯ Walker / ◯ Grab bars / ◯ Cane / ◯ Wheelchair / ◯ Tub Bench / ◯ Lift Chair / ◯ Others

Have you had any of the following for this condition? What were the results?

◯ None ◯ X-Ray _____ ◯ MRI _____	◯ CT Scan _____ ◯ Bone Scan _____ ◯ Arthrogram _____	◯ EMG _____ ◯ Diagnostic Arthroscopy ◯ Doppler/Ultrasound

Are you on medication for this injury?: _____

◯ Prescribed or ◯ Over the Counter?

How many falls last month? _____ Last year? _____

Is there an attorney involved?: ◯ Yes ◯ No

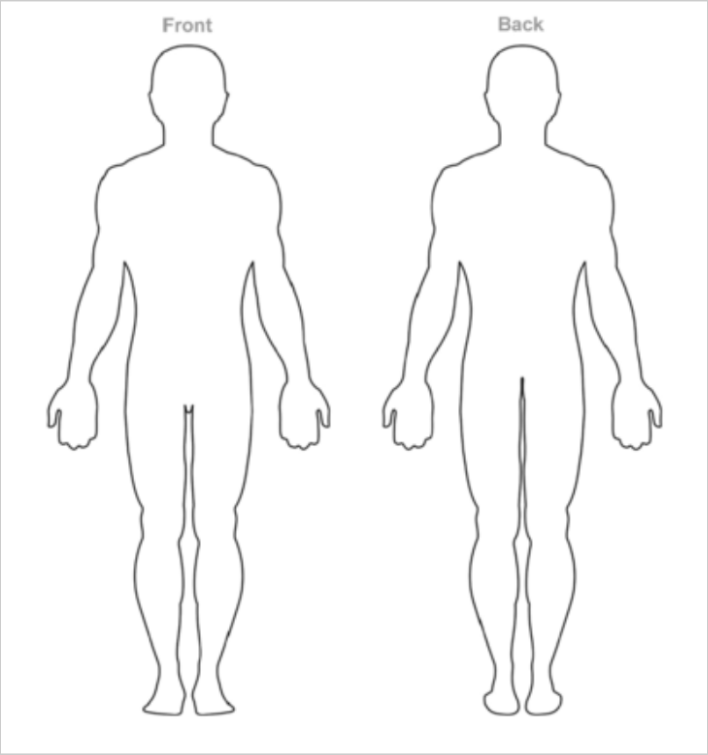
Are you currently receiving home health services?: ◯ Yes ◯ No

Has your injury hindered you from working? ◯ Yes ◯ No

Pain Questionnaire

To the best of your ability, please fill this out regarding your pain

*Please indicate the location of your pain



Describe your pain? (select more than 1)

◯ Tingling	◯ Piercing	◯ Aching
◯ Dull	◯ Numbness	◯ Burning
◯ Superficial	◯ Sharpness	◯ Deep
◯ Sharp	◯ Intermittent	◯ Stabbing

Please rate your pain on a scale of 0 to 10: 0 - no pain 10 - excruciating pain

_____ Worst it has been
_____ At this moment
_____ Best
_____ Activity

Are your symptoms worse in
◯ Morning
◯ Afternoon
◯ Evening
◯ Inconsistent

Which side? ◯ Left / ◯ Right

Which of the following causes pain
◯ Sitting
◯ Standing
◯ Walking
◯ Stairs - up
◯ Stairs - down
◯ Sit to stand
◯ Bending
◯ Voiding
◯ Lying Down
◯ Cough

Which of the following are some of your goals for physical therapy?

◯ Decrease Pain	◯ Improve Health
◯ Less Difficulty with Work Activities	◯ Stand Longer Than _____ Minutes/Hours
◯ Sleep Longer Than _____ Hours	◯ Sit Longer Than _____ Minutes/Hours
◯ Improve Movement	◯ Less Difficulty with Home Activities
◯ Return to Recreational Activities/Sports	◯ Ability to use Stairs

Any additional goals for PT? _____

Health History

Current Medications

◯ None / ◯ Prescription / ◯ Over the Counter / ◯ Herbals / ◯ Vitamins / ◯ Other

Medical History

◯ No Known PMH ◯ Alzheimer's ◯ Cardiovascular Disease ◯ Cauda Equina Syndrome ◯ Cerebral Vascular Accident ◯ Current Infection ◯ Diabetes Mellitus Type 1	◯ Diabetes Mellitus Type 2 ◯ Fibromyalgia ◯ Fracture ◯ High Blood Pressure ◯ History of Cancer ◯ Huntington's ◯ Immunosuppression ◯ Lupus	◯ Muscular Dystrophy ◯ Obesity ◯ Osteoarthritis ◯ Parkinson's ◯ Rheumatoid Arthritis ◯ Traumatic Brain Injury ◯ Other _____

Authorization

Notice of Privacy Practices

I certify that I am the patient or legal guardian that has been listed. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to AHPT. I authorize this office and its staff to examine/treat my condition as the seen fit. I hereby authorize the office to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between the insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Privacy Practices

I acknowledge that I was provided with a copy of the *Notice of Privacy Practices* and that I have read or had an opportunity to read and understand the notice.

◯ ***I agree to the statement of authorization***

Final Signatures

Name of the Insured (Printed) _____

Patient Signature _____

Guardian Signature _____