# PATIENT INTAKE SHEET

**The following questions are asked to help determine any limitations to treatment that may apply in your case.**

Patient name _____***Best phone number to call you*** _____

When did current problem start _____What part of your body? _____

Have you had surgery for this problem? _____ Date _____

Is this problem related to employment? _____ Auto accident? _____ Other accident? _____

If this problem is from an accident, did the accident occur in Oklahoma? No_____Yes_____ If No, where? _____

Do you have an attorney involved? Yes / No If Yes, Attorney's name and phone _____

Have you been treated here in the past for any reason? _____ If yes, about what year? _____

Have you had Physical Therapy treatment for this same problem anywhere else? _____

If yes, where? _____ What year? _____

Are you currently receiving treatment from any of the following (for any reason):

| | | | | | |
|---|---|---|---|---|---|
| Another physical therapist? | Yes | No | Speech therapy services? | Yes | No |
| Chiropractic treatment? | Yes | No | Occupational therapy services? | Yes | No |

Have you had home health or hospice for any reason recently? _____ When _____

If yes, who provided it? _____ Phone number _____

When is your next appointment with the doctor who sent you for physical therapy? _____

Who is your primary care doctor? _____ Phone _____

Have you fallen in the last 12 months? No_____Yes_____ If yes, How many times?_____Approximate date(s)_____

Have you had an eye exam in the past 12 months? No_____Yes_____

Is there anyone you want to have access to your physical therapy record other than the party we are billing? Yes / No

If yes, provide name and relationship _____

Please read and initial the following items:

_____*This information is true and accurate to the best of my knowledge and I understand billing will be based upon the information provided.*

_____*I authorize release of insurance benefits and release of information necessary to process my claim to Mid-Del Physical Therapy Clinic, Inc. for the services I receive.*

_____*I understand that I am ultimately responsible for the bills incurred for treatment.*

_____*I received a copy of HIPAA Notification Form and a copy of the Office Policies.*

*The above information is true and accurate to the best of my knowledge. I agree to have treatment in this clinic.*

Signature_____Date_____