

Patient Name _____ Acct # _____ Date: _____



Wholistic Physical Therapy Patient Intake and Registration

Patient Information	Last Name		First Name		MI	FEMALE	DOB	Age
						MALE		
	Address		Apt		City		State	Zip
	Email			Cell Phone		Home Phone		
	Primary Care Physician				Phone#		Marital Status	
	Cell Phone Disclaimer: By providing your cell number, you authorize our office or agents to contact you.							
	Emergency Contact			Relationship			Cell Phone #	
SSN – Last 4 (legal guardian if under 18)			Employer Name			Employer #		

Insurance Coverage	Primary Insurance		Claims Mailing Address (Listed on the back of card)				
	Policy #		Group #		Effective Date		
	Policy Holder Name (if not self)		DOB		Relationship to Patient		
	Secondary Insurance		Claims Mailing Address (Listed on the back of card)				
	Policy #		Group #		Effective Date		
	Policy Holder Name (if not self)		DOB		Relationship to Patient		

Auto/Work Claim	Do You Have Work/Auto Claim Information		Date of Injury		Claim #	
	YES NO Which One? Work Auto					
	Insurance Name			Claims Mailing Address		
Attorney/Adjuster Name			Attorney/Adjuster Phone #			

Authorization, Release of Information, and Financial Responsibility

I certify that all the information provided is accurate and complete. I authorize Wholistic Physical Therapy to release or obtain medical information as needed for coordination of care and billing purposes, including communication with insurance companies, case managers, attorneys, employers, schools, or other healthcare providers. I authorize direct payment to Wholistic Physical Therapy and accept full financial responsibility for any remaining balances not covered by insurance. I agree to notify the clinic of any changes to my insurance coverage. I understand that all sales of cash-based physical therapy sessions and packages are final, non-refundable, and redeemable only at the original location of purchase. Unused sessions may be transferred to family or friends but cannot be used at other locations. By signing below, I acknowledge that I have read, understand, and agree to the above terms. If the patient is a minor, I confirm that I am the legal guardian authorized to provide consent.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____

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Clinical and Medical History Related to Physical Therapy

At Wholistic Physical Therapy Clinic, your care starts with truly understanding you. By thoughtfully completing this form, you're helping us create a personalized treatment plan that supports your healing from every angle. Please be as thorough as you can, and if there's anything else you'd like us to know, don't hesitate to share it with your therapist. We appreciate your time and your trust in us.

Current Condition(s) or Reason for Visit

Condition or Issue Requiring PT: _____

Date Symptoms Started or Injury Occurred: _____

Area(s) of Discomfort or Pain: _____

Is your Discomfort or Pain Intermittent Constant

Do you have any of the following symptoms: Numbness Tingling

Have you had any of the following tests/procedures since your injury?

X-rays MRI CT Scan Bone Scan Comments:

What are you hoping to improve or achieve with therapy? _____

Have You Recently Experienced Any of the Following?

- Sores, wounds, or skin that won't heal
- Pain that worsens at night
- Referred Pain (Felt in a Different Area Than the Source)
- Pain not relieved by changing positions
- Pain That Increases with Rest Rather Than Activity

Physical Therapy Treatment History

Have you received physical therapy within the last 12 months? NO YES

If yes, please indicate where you received therapy and the reason for treatment.

Briefly describe the physical therapy treatment provided:

Functional Status and Activity Level

Prior to your condition or injury, how would you rate your ability to perform self-care and home management activities (e.g., dressing, bathing, cooking, or household chores)?

Excellent Good Fair Poor

Please rate your current ability to perform self-care and home management activities (e.g., dressing, bathing, cooking, or household tasks):

Excellent Good Fair Poor

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General Health and Medical History

Height _____ Weight _____ Pregnant? Yes No If Yes, Physician _____

What type of exercise or activity did you participate in prior to this condition? _____

How often did you participate in this activity or form of exercise? _____
Number: _____ Times per week _____ Times per month _____
Other: Specify _____

Do you smoke? YES NO *If yes, frequency* _____
less than 1 pack per day Alcohol use: how often? _____ Times/ week _____
more than 1 pack per day Times/ month _____
Other: _____

Have you ever had surgery? Yes No If Yes list, please list dates/type of surgery: _____

Has your doctor told you to avoid or restrict any activities? If so, which ones? _____

Is a follow-up visit with your physician scheduled? Yes No If yes, date? _____

Please list your current physicians: _____

Health Conditions Checklist: Please mark any that apply to your medical history or current care

- | | | |
|---|--|---|
| <p>Cardiovascular</p> <ul style="list-style-type: none"> Congenital heart disease Heart pacemaker Heart trouble / disease High blood pressure Low blood pressure <p>Developmental/Neurological</p> <ul style="list-style-type: none"> Autism Spectrum Disorder (ASD) Cerebral Palsy Developmental disorder Sensory Processing Disorder (SPD) <p>Endocrine</p> <ul style="list-style-type: none"> Diabetes Thyroid disease <p>Gastrointestinal</p> <ul style="list-style-type: none"> Hepatitis A Hepatitis B or C Liver disease Stomach and intestine disease <p>General</p> <ul style="list-style-type: none"> Cancer (current or history) Type: _____ Fatigue/Chronic Fatigue Syndrome History of Falls Recent weight loss | <p>Hematologic</p> <ul style="list-style-type: none"> Anemia Blood disease Deep Vein Thrombosis (DVT) History of blood clots <p>Immune System</p> <ul style="list-style-type: none"> AIDS / HIV positive Allergies; List: _____ Autoimmune disorder Hay fever Sensitivity to latex <p>Infectious Disease</p> <ul style="list-style-type: none"> Shingles: Active Yes No MRSA or other resistant infections <p>Musculoskeletal</p> <ul style="list-style-type: none"> Arthritis / Gout Artificial joint History of Fractures _____ Orthopedic Surgeries Osteoporosis Other implants _____ Rheumatoid arthritis Scoliosis | <p>Neurological</p> <ul style="list-style-type: none"> Alzheimer's disease Epilepsy / Seizure Fainting spells / Dizziness Frequent headaches Multiple Sclerosis (MS) Spinal Cord Injury (SCI) Stroke <p>Ophthalmologic</p> <ul style="list-style-type: none"> Glaucoma Macular Degeneration Cataracts <p>Psychiatric</p> <ul style="list-style-type: none"> Anxiety / Depression Post-Traumatic Stress Disorder (PTSD) <p>Renal</p> <ul style="list-style-type: none"> Kidney problems <p>Respiratory</p> <ul style="list-style-type: none"> Asthma Chronic Obstructive Pulmonary Disease (COPD) Emphysema Pulmonary Fibrosis Tuberculosis |
|---|--|---|

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Current Medications:

Check here if you attached a medication list.

Medication	Dose	Frequency	Medication	Dose	Frequency

Family/Social History

Do you live alone? Yes No If No, who do you live with? _____

Are you currently working? Yes No What is your occupation? _____

Relevant Family Medical History _____

Living Environment

What type of home do you live in? 1-story home 2-story home Apartment Tri-level Other

Are stairs required to access or navigate your home? Yes No If yes, how many? _____

Handrailing present on: Left side Right side Both Sides No Hand Railing

Release of Information

Whom may we contact regarding your treatment and billing?

I hereby authorize Wholistic Physical Therapy to speak with the following individual(s) regarding my treatment and/or billing information:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone Number: _____ Phone Number: _____

I do **not** authorize Wholistic PT to share my treatment or billing info with anyone.

Signature: _____ **Printed Name:** _____

Date: _____

Consent to Treat and Acknowledgement of Privacy Practices

I hereby authorize **Wholistic Physical Therapy** and its licensed providers to evaluate and administer treatment as deemed medically necessary for the diagnosis, management, and rehabilitation of my physical condition. I understand that this may include physical therapy assessments, therapeutic interventions, and related healthcare services provided within the scope of practice.

I acknowledge that I have been informed of **Wholistic Physical Therapy’s Notice of Privacy Practices**, which describes how my health information may be used and disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA). I understand that a copy is available upon request and is also posted at the point of care.

By signing below, I affirm that I have read and understand the information above, and I consent to receive care under these terms.

Signature: _____ **Printed Name:** _____

Date: _____ **Relationship to Patient (if applicable):** _____