Patient Intake Forms

Name:_____ **Date of Birth:**____/____/_____ **Sex:** ☐ Female ☐ Male

Preferred Name: _____ **Preferred Pronouns:** _____

Height: _____ **Weight:** _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____

City, State + Zip: _____

Cell Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____

Email Address: _____ **Home Phone:** (_____) _____-_____

Preferred Reminder Method: ☐ Text ☐ Call ☐ Email

Occupation: _____ **Employer:** _____

Emergency Contact Name: _____

Emergency Contact Phone: (_____) _____-_____ **Relation to Patient:** _____

Preferred Language: ☐ English ☐ Other: _____

Have you had Physical Therapy this year for any condition? ☐ Yes ☐ No

If yes, for what condition(s):_____

How did you hear about Gnome Physical Therapy?

☐ Doctor ☐ Friend ☐ Social Media ☐ Other: _____

PHYSICIAN INFORMATION

Referring Physician:_____

Office/Clinic Name:_____

City/Town:_____

Primary Care Physician:_____

Office/Clinic Name:_____

City/Town:_____

PRIVACY PRACTICES

I acknowledge that I have received or have had the opportunity to receive a copy of the official Notice of Privacy Practices from Gnome Physical Therapy. For coordination of care, I understand Gnome Physical Therapy will share evaluations, progress notes, and other relevant details regarding my care with my referring provider, primary care provider, and/or insurance carrier if applicable.

Signature: _____ Date: _____

PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE
Relation to Patient: ☐ Parent ☐ Legal Guardian/Representative

CONSENT FOR COMMUNICATION

INITIAL: _____ I authorize Gnome Physical Therapy to leave detailed messages on my voicemail.

INITIAL: _____ To receive appointment reminders via my preferred method.

INITIAL: _____ To receive communication via text (standard messaging rates apply) from Gnome Physical Therapy.

INITIAL: _____ To receive communication via email from Gnome Physical Therapy.

INITIAL: _____ I authorize Gnome Physical Therapy to discuss my appointments or care with my spouse.

CONSENT FOR TREATMENT

I, the Undersigned or legal guardian thereof, do hereby agree and give my consent for Gnome Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating and/or treating my physical condition. This includes the use of HIPPA compliant, audio-recording, AI scribing software to facilitate provider documentation.

I authorize Gnome Physical Therapy to provide information concerning my treatment and insurance claims forms to my insurance carrier(s) on my behalf, and I authorize for payment of insurance benefits to be made directly to Gnome Physical Therapy for services rendered. In the event my insurance company forwards payment directly to me, instead of to Gnome Physical Therapy, I agree to promptly deliver said payment to Gnome Physical Therapy.

I authorize Gnome Physical Therapy to provide information concerning my treatment to my primary care provider or referring provider. I understand that this does not authorize release of medical information by Gnome Physical Therapy to any other organization or agency unless I grant further authorization. And if I do, I understand that those authorizations can be revoked at any time.

I understand that I am responsible for the total cost of care. If I do not provide insurance information or inaccurate information, I understand Gnome Physical Therapy will bill me directly for incurred charges as well as for charges not covered by my insurance plan. If I receive a notice from my insurance company that payment is delayed or denied because additional information is required from me, I agree to promptly contact my insurance company to provide that additional information.

If I have insurance, I understand I am responsible to know and understand the terms of my policy with my insurance carrier(s). I understand my insurance carrier(s) will make a final determination of benefits after a claim has been processed and that claims may be subject to limitations and exclusions. And I acknowledge my insurance may not cover medically necessary treatment provided by Gnome Physical Therapy.

If I have a copayment, I agree to pay the full copayment at the beginning of each of my appointments.

If I have a coinsurance, I agree to pay the estimated coinsurance at the beginning of each of my appointments. In the event of overpayment due to estimation, I understand I will be reimbursed the amount overpaid.

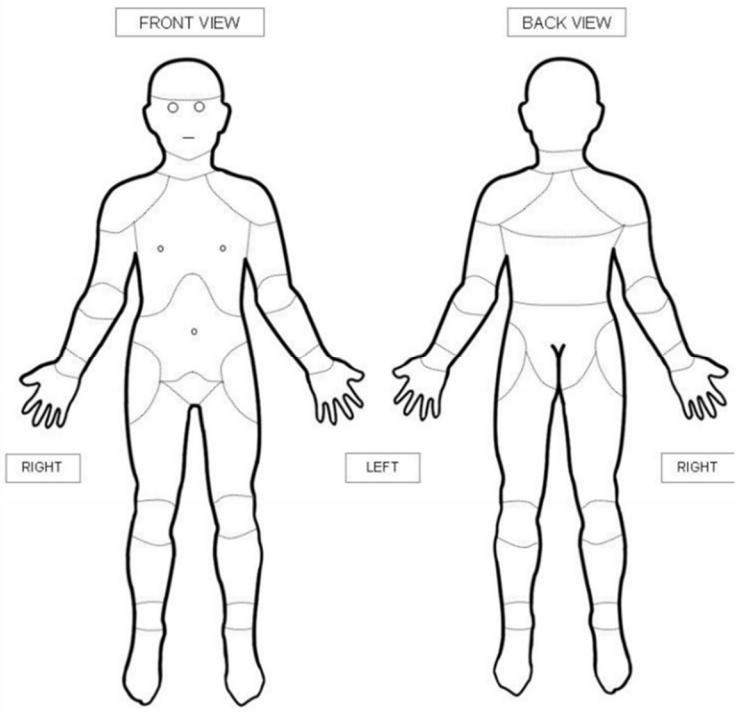
I agree to pay a $25 fee for any Cancellation or No Show without at least 24 hours prior notice to my scheduled appointment time.

Signature: _____ Date: _____

PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE
Relation to Patient: ☐ Parent ☐ Legal Guardian/Representative

CURRENT CONDITION(S)

On the images below, please mark the location(s) of your symptoms, pain, or injury with "X's":



How and when did your condition/injury/surgery begin or occur?

_____

_____

_____

_____

Do you currently have any restrictions from your doctor?

_____

Please list <u>at least 3 important activities</u> which you are unable to perform or have difficulty performing due to your current injury or problem, and rate your ability to perform the activities on the 0-10 scales below:

		Unable										No Difficulty
1.	_____	0	1	2	3	4	5	6	7	8	9	10
2.	_____	0	1	2	3	4	5	6	7	8	9	10
3.	_____	0	1	2	3	4	5	6	7	8	9	10
4.	_____	0	1	2	3	4	5	6	7	8	9	10
5.	_____	0	1	2	3	4	5	6	7	8	9	10

MEDICAL HISTORY

Please select any condition(s) you currently have, or have had previously:

Yes ☐ No ☐ Allergies
Yes ☐ No ☐ Anemia
Yes ☐ No ☐ Anxiety
Yes ☐ No ☐ Arthritis
Yes ☐ No ☐ Asthma
Yes ☐ No ☐ Cancer
Yes ☐ No ☐ Cardiac Conditions
Yes ☐ No ☐ Cardiac Pacemaker
Yes ☐ No ☐ Chemical Dependency
Yes ☐ No ☐ Currently Pregnant
Yes ☐ No ☐ Depression
Yes ☐ No ☐ Diabetes Type I ☐ Type II ☐
Yes ☐ No ☐ Dizzy Spells
Yes ☐ No ☐ Emphysema Bronchitis
Yes ☐ No ☐ Fractures
Yes ☐ No ☐ Gallbladder Condition
Yes ☐ No ☐ Hepatitis
Yes ☐ No ☐ High Blood Pressure
Yes ☐ No ☐ Incontinence
Yes ☐ No ☐ Kidney Condition
Yes ☐ No ☐ Metal Implants
Yes ☐ No ☐ Osteoporosis
Yes ☐ No ☐ Parkinson's Disease
Yes ☐ No ☐ Poor Circulation
Yes ☐ No ☐ Rheumatoid Arthritis
Yes ☐ No ☐ Seizures
Yes ☐ No ☐ Speech Condition
Yes ☐ No ☐ Strokes
Yes ☐ No ☐ Thyroid Disease: Hypo ☐ Hyper ☐
Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Visual Condition

If applicable, please describe any medical condition above and/or if you have a condition not previously listed:

_____

_____

SURGICAL HISTORY (May provide a printed list instead)

Body Region: _____ Procedure: _____ Date: _____
Body Region: _____ Procedure: _____ Date: _____
Body Region: _____ Procedure: _____ Date: _____
Body Region: _____ Procedure: _____ Date: _____
Body Region: _____ Procedure: _____ Date: _____
Body Region: _____ Procedure: _____ Date: _____

MEDICATIONS/Vitamins/Supplements (May provide a printed list instead)

Name: _____ Reason for Taking: _____
Name: _____ Reason for Taking: _____
Name: _____ Reason for Taking: _____
Name: _____ Reason for Taking: _____
Name: _____ Reason for Taking: _____
Name: _____ Reason for Taking: _____
Name: _____ Reason for Taking: _____
Name: _____ Reason for Taking: _____