BISHOP PHYSICAL THERAPY

Patient History

Name:_____ DOB:_____

Occupation:_____ Marital Status:_____

Reason for doctor's referral:_____

Is this injury related to work? Yes / No Is this injury related to an auto or other accident? Yes / No

If so and you have a case pending with a lawyer list the name and address of the responsible party. (We do not file third party claims through auto or other liability insurances):

_____

Date of Injury / Onset:_____ Cause of Injury:_____

Have you sought or are you currently seeking treatment for this condition from any of the following?

Massage Therapy, Chiropractic, Psychologist, Physical Therapy, Occupational Therapy

Describe Outcome:_____

Are you currently attending physical therapy for a separate condition in a facility other than Bishop Physical Therapy? Y / N

What goals would like to achieve from treatment?_____

What makes you feel better or feel worse?_____

Is there a time of day when your pain is worse?_____

Pain Rating: Please rate your pain on the scale below :

No Pain 0 >> 1 2 3 4 5 6 7 8 9 10 <<

Body Chart Legend: Mark body with the symptoms below:

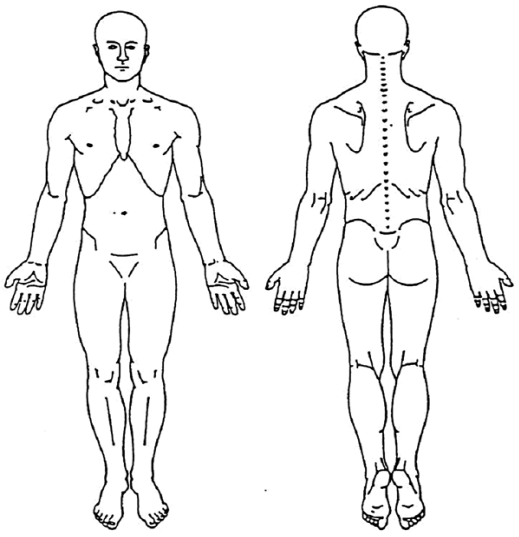
P – Pain

N – Numbness

T – Tingling, Pins, Needles

B – Burning

S – Swelling



Medical History

Circle any medical condition that may impact your treatment:

Osteoporosis	Osteopenia	Skin Rashes	Bowel Problems	Bladder Problems
Heart Disease	Stroke	Pacemaker	Defibrillator	High Blood Pressure
Hysterectomy	Cancer	Seizures	Hepatitis- A B C	HIV or AIDS
Fear of Falling	Depression	Lung Disease	Asthma	Difficulty Sleeping
Dizziness	Alcohol Abuse	Drug Abuse	Arthritis	Chest Pain
Gout	Tuberculosis	Diabetes	Mental Disorders	Kidney Disease
Physical Abuse	Fibromyalgia	Fracture	Bleeding Disorders	Nerve Damage

Other:_____

List any other medical conditions that may not be associated with your current problem but may be relevant to treatment?_____

List any current medications you are taking:_____

List relevant family history:_____

Do you smoke? Y / N How many packs per day?_____

Do you drink alcohol? How many drinks per day?_____

Are you on anti-inflammatory medication? Y/ N If so please list:_____

How many cups of water do you drink per day?_____ Caffeinated Drinks?_____ Energy Drinks?_____

How many hours of sleep do you get each night?_____

Do you perform any activities at home or work that my impact your treatment? Y/ N

List activities: _____

Do you have assistance of family/friends if you require help with your daily activities? _____

Hobbies: _____

Does your injury limit your personal/social life? Y/ N

List limitations: _____

Does your injury keep you from performing your daily task at work? Y /N

List limitations: _____

Does your injury limit your mobility or ability to care for yourself? Y / N

Explain: _____

Do you feel you can improve with therapy?_____

During the past month have you been bothered by feeling down, depressed, or hopeless? Yes No

During the past month have you lost interest or pleasure in doing things? Yes No

BISHOP PHYSICAL THERAPY PATIENT INFORMATION

Physical Therapy Intake Form

Name:_____ DOB:_____

Address:_____

Phone Number:_____ Email:_____

Referring Physician:_____ Medical Diagnosis:_____

Does your insurance require you to select a PCP physician? Y / N PCP Physician:_____

Are you currently receiving treatment through Home Health Care? Y / N

Primary Insurance Information

Primary Insurance:_____ Policy Number:_____

Policy Holder's Name:_____ Relationship to Patient:_____

Policy Holders DOB:_____

Secondary Insurance Information

Secondary Insurance:_____ Policy Number:_____

Policy Holder's Name:_____ Relationship to Patient:_____ DOB:_____

Work Comp/Auto Accident/Liability

Insurance Company / Lawyer's Office_____

Phone Number:_____ WC Claim Number:_____

Claims Adjuster Name:_____ Lawyer's Name:_____

In an effort to remind you of your appointments this office will contact you by the phone number you have listed. Please indicate which of the following actions you authorize in the event that we cannot contact you directly:

____Leave a message on my voicemail or answering machine

____Leave a message with my spouse/other family member should they answer my phone

____If you cannot contact directly me do not leave a message. **I do understand that Bishop Physical Therapy has a no show policy/cancelation policy which may result in you being charged a $35.00 fee for missing an appointment without a 24 hour notice**.

Initial the following:

_____**Consent to Treat:** I consent to rehabilitation services with Bishop Physical Therapy. I understand that such rehab may involve bodily contact, touching, and direct contact of a sensitive nature. Also, that my Physical Therapist must have visual or physical access to the areas of my body which may be experiencing dysfunction. I understand that it is my responsibility to communicate any concerns or modesties I have regarding my treatment immediately. I agree to verbalize all concerns I may have to my treating therapist. As with any course of treatment, there is always the possibility of an unexpected complication

and no guarantee has been made as to the results of treatment. I understand treatment could cause soreness, bruising, or other side effects or reactions. I have expressed all concerns for this and have agreed to all treatment.

_____**Assignment of Benefits:** I hereby assign all benefits directly to Bishop Physical Therapy and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be held financially responsible.

_____**Notice of Privacy:** I acknowledge receipt of Notice of Privacy Practices.

I certify that all of the above information is true and correct. I authorize my insurance carrier to pay Bishop Physical therapy directly for services performed. I understand that I am financially responsible for payment of all copays, deductibles, and balances not covered by my insurance. If I cancel or do not show for an appointment I understand that I may be charged a $30 fee.

Patient Signature:_____ **Date:**_____