Pacific
PHYSICAL THERAPY
1950 Pottery Ave Ste. 110, Port Orchard, WA 98366
T. 360.329.7052 • F. 360.329.7053

Patient Intake Form

Patient Information

First Name_____ MI _____ Last Name_____

DOB_____/_____/_____ Age:_____ Social Security #_____-_____-_____ ◯ Male ◯ Female

Address_____
Street *City* *State* *Zip*

Email address _____

Home Phone (____)_____-_____ Work Phone (____)_____-_____ Cell Phone (____)_____-_____

Contact Preference ◯ *home phone* ◯ *work phone* ◯ *cell phone* ◯ *email*

Responsible Party (If other than patient)

Name_____ home phone (____)_____-_____ work phone (____)_____-_____

Address_____
Street *City* *State* *Zip*

Emergency Contact

Name _____Relationship _____Phone (____)_____-_____

Employer

Employer Name_____ Phone (____)_____-_____

Address _____
Street *City* *State* *Zip*

Injury Information

Referring Physician _____ Primary Care Physician _____

Date of Injury _____ Injury/body part_____

Place of Injury_____ Cause of Injury_____ Surgery Date_____

Employment Related? ◯ Yes ◯ No Auto Accident? ◯ Yes ◯ No Available PIP? ◯ Yes ◯ No

Responsible Party_____ Phone (____)_____-_____

Adjuster/Claim Manager Name_____ Phone (____)_____-_____

Have you had previous PT or OT this Year? ◯ Yes ◯ No Are you receiving any in-home therapy? ◯ Yes ◯ No

Insurance Information • *Please present your insurance cards to the front desk for scanning*

Primary Insurance _____Subscribers Name_____

DOB _____/_____/_____ ID Number_____ Group Number_____

Secondary Insurance _____Subscribers Name_____

DOB _____/_____/_____ ID Number_____ Group Number_____

I hereby authorize my insurance benefits to be paid directly to the provider of these services. I am financially responsible for any balance due, including services that are not covered by my insurance plan. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original. If appointments are cancelled with less than 24 hour notice there is a $30 cancellation fee that will be the patients responsibility.

Signature _____ Date_____
(Parent or Guardian if patient is a minor)

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Health History Form

Patient Name_____

Please fill out the following questionnaire as completely as possible. This enables your therapist to design a safe and appropriate treatment plan for you. Your input is very important.

Patient Information

How did you hear about us? _____

_____

Age_____ Height _____ Weight _____

Referring Physician _____

Date of last visit _____ Date of next visit_____

Occupation _____

Current Status ◯ Full time ◯ Part Time ◯ Retired
◯ Normal Duty ◯ Light Duty

Case History

Date of Onset _____ Due to _____

Briefly describe your symptoms _____

_____

_____

Recent symptom trend ◯ Better ◯ Worse ◯ Same

Surgery ◯ Yes ◯ No Date _____

Surgery performed _____

Diagnostic Testing (check all that apply) ◯ None ◯ MRI
◯ X-Ray ◯ Bone Scan ◯ CT Scan ◯ EMG ◯ NCV

Other _____

Results if known _____

_____

Current Complaints

◯ Difficulty Walking ◯ Imbalance
◯ Loss Function ◯ Numbness ◯ Tingling ◯ Pain
◯ Stiffness/ Tightness ◯ Weakness ◯ Other

_____

Pain

Pain Frequency ◯ Constant Steady ◯ Constant Variable
◯ Comes & Goes ◯ Occasional (less than daily)
◯ Sporadic (less than weekly)

Pain Quality ◯ Aching ◯ Burning ◯ Dull
◯ Pulsing ◯ Stabbing ◯ Steady ◯ Throbbing

Pain Behavior

Pain Rating on a scale from 0 to 10 - Circle One
(0 - no pain, 10 - Worst pain you can imagine)

What is the Worst your pain has been? 1 2 3 4 5 6 7 8 9 10
What is your current Pain? 1 2 3 4 5 6 7 8 9 10
What is the Best your pain has been? 1 2 3 4 5 6 7 8 9 10

Does time of the day affect your symptoms? ◯ Yes ◯ No
Do you have any numbness or tingling? ◯ Yes ◯ No
Where _____
What activities make you better? _____

_____

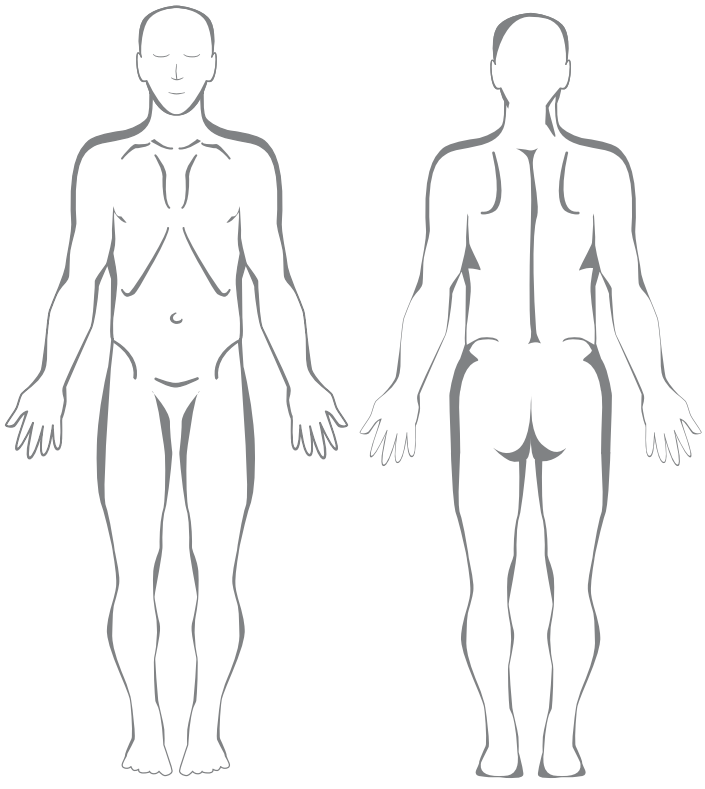
What activities make you worse? _____

_____

Functional level at present (List the activities that you are currently *unable* to do because of your diagnosis/ pain)

_____

Draw the painful areas on the body diagram



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Health History Form *part 2*

Patient Name_____

Medical History

Check if you are **currently** taking, or **have recently** taken any of the following medications. *(circle all that apply)*

Steroids (cortisone)
Anti-inflammatory
Pain Killers
Heart medication
Muscle relaxants
Blood pressure medication
Insulin (diabetes)
Anti-coagulants (blood thinners)
Other _____

I currently have, OR had a history of. *(circle all that apply)*

Coronary artery disease
High Blood Pressure
Headaches
Pacemaker/ Nitroglycerin patch
Heart trouble/angina
Frequent falls
Dizziness
Blackouts
Difficulty with blurry vision
Numbness around lips
Poor Circulation
Epilepsy/seizures
Diabetes
Cancer/tumors
Shortness of breath
Asthma
Allergies
Severe pain at night
Bruising easily
Thyroid problems
Osteoporosis
Hearing problems
Bowel/Bladder Problems
Night sweats
Drop attacks \ Fainting
Fever
Fatigue
Nausea
Major injury to neck/ spine/ back
Smoking/Tobacco use
Alcohol use
Caffeine intake
Unexplained weight loss
Unexplained weight gain
Weakness or tingling in both arms and legs
Chest, abdominal, or pelvic surgery
Osteoarthritis

Surgical History: _____

Medical Screening Tests

FEMALES:

I have had a pelvic exam (PAP) within the last twelve months.
◯ Yes ◯ No

I have had a mammogram or breast exam within the last twelve months. ◯ Yes ◯ No

I am or may be pregnant. ◯ Yes ◯ No

MALES:

I have had a prostate exam within the last twelve months.
◯ Yes ◯ No

Other Complaints _____

Related Habits

Are you physically active? ◯ Yes ◯ No

Do you exercise regularly? ◯ Yes ◯ No

If yes, what do you do? _____

Have you been able to continue? ◯ Yes ◯ No

Goals

What are your goals with therapy?

_____

_____

_____

Previous treatment _____

_____

_____

Authorization for Treatment

I authorize the therapists of Pacific Physical Therapy to administer such treatment as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment. The information provided is accurate to the best of my knowledge.

Signature _____ Date_____

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Medication List

Patient Information

Patient Name_____ Date _____

Referring Practitioner _____

Please list ALL medications (including prescription, over-the-counter, herbals, vitamins, minerals, dietary or nutritional supplements) which you may be taking routinely and / or on as needed basis.

	Medication	Dosage	Times Per Day	Route (oral, injection, etc)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

This information has been reviewed with the patient (or authorized representative) to confirm accuracy.

Signature _____ Therapist Initals _____

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Financial Policy

Please carefully review our financial policies and office policies to answer any questions you may have regarding your services with us.

- All co-pays are due at the time of service.
- We accept cash, checks, Visa and Mastercard.
- Payment in full may be due at the time of service depending upon services rendered.

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you we will bill your insurance provider for the services rendered. Your contract dictates the services that are covered and the amount of payment for those services. You are responsible for payment of services provided, a physician's referral and our verification of insurance does not guarantee payment. Please advise our clinic of any changes or updates in address, insurance, phone, new injury or employment changes to ensure accurate billing.

Medicare Patients: As of January 1,2006 Medicare has a dollar amount cap for outpatient Physical Therapy benefits. Your supplemental plan may provide coverage beyond this cap. It is your responsibility to be aware of the remaining benefits under Medicare. This waiver is an acknowledgement that you are aware of the Medicare cap and that you are responsible for paying the balance on any visits that Medicare or your insurance does not.

Workers Compensation Claims/Self-Insured Claims: Please provide the office the name and phone number of your claims representative before you begin treatment. We request your private insurance information at the time of service. If your L&I claim is not accepted we will bill your private insurance. You are responsible for payment of services rendered if your claim is not accepted.

Motor Vehicle Collisions: We will bill your Personal Injury Protection Insurance (PIP) as a courtesy to you. However, you are fully responsible for the bill. In the event that payment has not been made within 30 days, you will be required to make payment arrangements.

Private Pay/No Insurance: Full payment is due at the time of service.

Doctor Referrals: You are responsible for obtaining a referral and/or prescriptions from your primary care physician prior to your appointment. It is your responsibility to make sure we have a valid and current copy of your referral/prescription in the office at the time of your appointment. Exceptions to this policy are plans that have direct access to therapy with no referral required.

Cancellations and No Show appointments: If you are unable to make your scheduled appointment we ask that you contact our office to cancel your appointment. If appointments are cancelled with less than 24 hour notice there is a $30 cancellation fee that will be the patient's responsibility.

Payment Issues: Please contact our Billing department as soon as possible if financial problems arise. If an account becomes past due, necessary action will be taken, up to and including collections or legal action. The undersigned understands that he/she or his/her agent is responsible for charges incurred.

I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that the benefits quoted to me are not a guarantee of claim payment. I understand that payment is dependent on my eligibility at the time of service and ALL terms and conditions of my insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges.

I authorize Pacific Physical Therapy to release any necessary information requested by my insurance carrier and authorize payment directly to Pacific Physical Therapy for any benefits available under my insurance plan. I have read and understand the above mentioned and consent to evaluation and treatment. I have carefully read the Financial Policy and agree to the terms therein.

Signature of Patient or Responsible Party

Date

Print Name

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Notice of Privacy Practices Acknowledgement of Receipt

Check one box:

☐ I acknowledge receipt of a copy of the Notice of Privacy Practices.

☐ I have been offered a copy of the Notice of Privacy Practices for Pacific Physical Therapy, but I have chosen to decline a copy at this time.

Check all that apply:

☐ In addition to those described in the Privacy Policy, I give my permission for PPT to discuss my health care and billing information with the following people:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

☐ Phone: I give PPT permission to leave a detailed message on my voicemail/ answering machine.

☐ Email: I give PPT permission to send me email messages regarding my care, educational newsletters and upcoming clinic events. {*We will not sell or distribute your email address to any other entity.*}

Email address_____

_____

Patient or Guardian Signature Date

_____

Print Name