STILLINGS-SMITH PHYSICAL THERAPY
PATIENT INTAKE AND CONSENT FORM

ACCOUNT #__________________________________ACCOUNT TYPE___________________________

First Name _______________________________ MI______ Date of injury/Onset____________________

Last Name _____________________________ Date of Birth______________________ Age ____________

Address ___________________________________ Sex M F Marital Status S M D W

City _____________________________ St____ Zip ___________ SS # ____________________

Phone: H__________________Wk________________Cell__________________E-Mail__________________

Injury Area ____ Accident Related: Yes No

If Accident: Auto Work Other Nature of Accident ____________________________________

Claim Filed: Yes No PIP Filed: Yes No Presently Working? Yes No Restricted Duty

Employer ____

Address ____________________________________ City _____________________ St _____ Zip__________

Contact Person @ Work: ____

Occupation: ____

Referring Physician ____________________________________ Phone #_________________________

Primary Physician _____________________________________ Phone # _________________________

EMERGENCY CONTACT _____________________________ Phone # _________________________

Primary Ins. ______________________________________ Subscriber ID# ___________________________

Billing Address: ____ Phone # ________________________

Subscriber's Name:____ D.O.B._____________________

Patient Relation to Insured: Self, Spouse, Child, Other Deductible/Copay: _________________

Verification/Comments: ____

____Verified by: _________________________

Secondary Ins. ____________________________________ *Subscriber's ID#*____________________________

Billing Address: ____Phone#: __________________________

Subscriber's Name: ____ Subscriber's DOB: _______________

Patient Relation to Insured: Self, Spouse, Child, Other Deductible/Copay: _________________

Verification Comments: ____

Insurance verification is not a guarantee of payment or accuracy of benefits. Please call your member services directly for physical therapy benefits.

PLEASE COMPLETE OTHER SIDE->

INSURANCE COVERAGE INFORMATION:

Are you presently receiving home care services (therapy, nursing, home health aide)? ☐Yes ☐No

Have you recently received home care services, (therapy, nursing, home health aide)? ☐Yes ☐No

If yes, discharge date: _____Name of Agency: _____

CONSENT TO TREATMENT: I consent to rehabilitation and related services at SSPT. In so doing, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

Initial _____

TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

Initial _____

LIABILITY: I agree that SSPT is not responsible for loss or damage to personal valuables.

Initial _____

WAIVER AND RELEASE: I hereby release, discharge and acquit SSPT, it's agents, representatives, affiliates, employees, or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind, arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician, or urgent care services.

Initial _____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to SSPT 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 financially responsible for payment. I understand that if my account is sent to collections, the additional charges of up to 35% of billed charges will be added to my account for collection services.

Initial _____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices.

Initial _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Date _____

Witness Signature _____

STILLINGS-SMITH PHYSICAL THERAPY

MEDICAL HISTORY FORM

PATIENT NAME: _____ **TODAY'S DATE:** _____
REFERRING PHYSICIAN'S NAME: _____ **DATE OF INJURY OR ONSET:** _____
PRIMARY CARE PHYSICIAN'S NAME: _____ **DATE OF NEXT MD APPT:** _____
CAUSE OF INJURY OR ONSET: _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

_____

_____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

SURGICAL/HOSPITALIZATION/THERAPY HISTORY:

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES/NO IF YES, WHEN AND WHY_____

LIST YOUR SURGICAL HISTORY_____

_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES/NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?:

_____

CURRENT HEALTH STATUS:

DO YOU CURRENTLY USE TOBACCO?(cirlce one) YES/NO, IF YES HOW MUCH?_____

DO YOU WEAR GLASSES/CONTACTS? YES/NO

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES/NO
IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES/NO IF YES, WHERE: _____

CURRENT MEDICATIONS: _____

_____

STILLINGS-SMITH PHYSICAL THERAPY

MEDICAL HISTORY FORM(page 2)

ALLERGY HISTORY:

ALLERGIES: Medication _____Reaction_____ Other _____Reaction_____
ARE YOU ALLERGIC TO LATEX? (circle one) YES/NO If yes what is the Reaction_____
Are you Allergic to Dexamethasone? YES/NO If yes what is the Reaction_____

FALL HISTORY:

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES/NO

IF YES, HOW MANY TIMES: _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES/NO

OCCUPATIONAL HISTORY:

ARE YOU CURRENTLY WORKING? YES/NO IF YES, ARE YOU WORKING FULL DUTY/MODIFIED(circle one)

IF NO, WHEN WAS YOUR LAST DAY WORKED?_____

ARE YOU OUT OF WORK AS A RESULT OF YOUR CURRENT SITUATION? YES/NO

WHAT IS YOUR JOB TITLE?_____WHO IS YOUR EMPLOYER?_____

PLEASE BRIEFLY DESCRIBE YOUR JOB DUTIES: _____

_____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

□ ANEMIA
□ ARTHRITIS
□ CANCER
□ CARDIOVASCULAR PROBLEMS
□ HOLTER MONITOR - currently wearing?
□ PACEMAKER
□ HIGH BLOOD PRESSURE
□ controlled □ uncontrolled
□ LOW BLOOD PRESSURE
□ CURRENTLY PREGNANT
□ DIABETES □controlled □uncontrolled
□ DEPRESSION
□ DIZZINESS/FAINTING
□ FRACTURES
□ HEADACHES
□ HEPATITIS/HIV
□ KIDNEY PROBLEMS
□ MRSA (Methicillin Resistant Staphylococcus Aureus)
□ OSTEOPOROSIS
□ RESPIRATORY PROBLEMS
□ ASTHMA □ controlled □ uncontrolled
□ COPD □ controlled □ uncontrolled
□ Other
□ SEIZURES □ controlled □ uncontrolled
□ THYROID PROBLEMS
□ BLOOD THINNERS (Anticoagulants)

☐ **ANY OTHER MEDICAL PROBLEMS: _____**

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____Date_____