Art of Health Physical Therapy, P.C.

Ortho Patient Intake

Name:_____ **Date**_____

Address_____

Home Phone#_____ Cell Phone#_____

Date of Birth_____ Age_____ E-mail_____

Referring Physician_____

Address_____

Tel#_____Fax#_____

Primary Physician_____

Address_____

Tel#_____ Fax#_____

1.Describe the current problem that brought you here _____

_____

2.When did your problem first begin?_____months/years ago

3.Was your first episode of the problem related to a specific incident? ❑Yes ❑No
Please describe and specify date _____

_____

4.Since that time is your symptoms: ❑same ❑getting worse ❑getting better?
Why or how?_____

_____

5.If pain is present, rate pain on a 0-10 scale (0=no pain;10=worst pain):._____

6.Describe the nature of the pain: ❑constant ❑intermittent ❑burning ❑ache
❑soreness ❑muscle spasms ❑stabbing

Others_____

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Name _____ **Date** _____ **(page 2)**

7.Previous treatment for your condition: ❑PT ❑Chiropractor ❑Acupuncturist ❑Psych ❑Nutritionist ❑Colorectal ❑Pain mgmt ❑Urogynecologist
Others _____

8.Activities that cause or aggravate your symptoms. **Check all that apply**

❑Sitting greater than _____ minutes
❑Cough/sneeze/straining
❑Walking greater than _____ minutes
❑Laughing/yelling
❑Light activity (light housework)
❑Vigorous act/exercise (run/weight lift/jump)
❑With nervousness/anxiety
❑Changing positions (sit to stand)
❑Lifting/bending
❑Standing greater than _____ minutes
❑Cold weather
❑Sexual activity
❑With triggers (running water/key in door)
❑No activity affects the problem

Others please specify _____

9.What relieves your symptoms? _____

_____

10.How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify _____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____

11.Rate the severity of this problem from ***0 -10 with 0=no problem and 10=worst*** _____

12.What are your treatment goals/concerns? _____

_____

13.Since the onset of your current symptoms have you had: (check all that apply)

❑Fever/Chills
❑Unexplained weight change
❑Dizziness or fainting
❑Change in bowel/bladder functions
❑Malaise (Unexplained tiredness)
❑Unexplained muscle weakness
❑Night pain/sweats
❑Numbness / Tingling

Others (describe) _____

_____

_____

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Name _____ **Date** _____ **(page 3)**

14.**Health History:** Date of Last Physical Exam _____
Tests performed (if any) _____

15.**General Health:** ❑Excellent ❑Good ❑Average ❑Fair ❑Poor
Occupation _____ Hrs/wk _____ ❑Not working ❑Retired

16.**Mental Health**: Current level of stress ❑High ❑Med ❑Low
Are you currently receiving psychological therapy? ❑Yes ❑No

17.**Activity/Exercise**: ❑None ❑1-2 days/wk ❑3-4 days/wk ❑5+ days/wk
Describe _____

18.**Have you ever had any of the following conditions or diagnoses? (check all that apply /describe)**

❑Cancer	❑Stroke	❑Emphysema
❑Heart problems	❑Epilepsy/seizures	❑Asthma
❑High blood pressure	❑Multiple sclerosis	❑Chronic bronchitis
❑Ankle swelling	❑Head Injury	❑Latex sensitivity
❑Anemia	❑Osteoporosis	❑Hypothyroid/
❑Hyperthyroid	❑Low back pain	❑Headaches
❑Chronic fatigue syndrome	❑Sacroiliac/tailbone pain	❑Diabetes
❑Alcoholism/drug problem	❑Arthritic conditions	❑Kidney disease
❑Childhood bladder problems	❑Stress fracture	❑Irritable Bowel Synd
❑Depression	❑Hepatitis HIV/AIDS	❑Rheumatoid Arthritis
❑Anorexia/bulimia	❑Joint Replacement	❑Sexually transmitted dz
❑Smoking history	❑Bone Fracture	❑Physical/sexual abuse
❑Vision/eye problems	❑Sports Injuries	❑Raynaud's/cold hands/feet
❑Hearing loss/problems	❑TMJ/ neck pain	❑Pelvic pain

Other/Describe _____
Allergies _____

19.**Surgical /Procedure History: (please check all that apply & specify dates)**

❑back/spine surgery _____	❑bladder/prostate surgery _____
❑brain surgery _____	❑bones/joints surgery _____
❑abdominal surgery _____	❑Other/describe _____

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Name _____ **Date** _____ **(page 4)**

20. **Medications** (pills, injection, patch) Start date Reason for taking

_____

_____

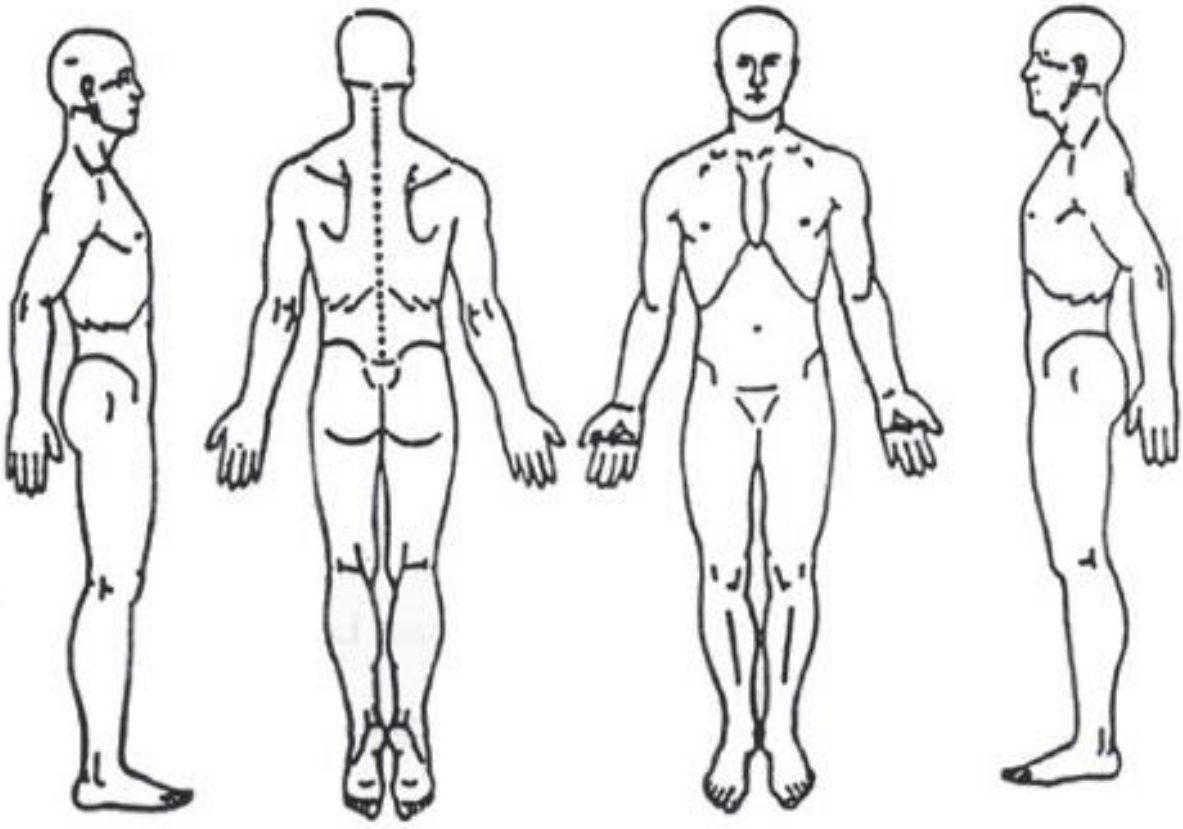
_____

_____

_____

_____

Please indicate on the body chart below where your symptom(s). Try to write a brief description such as: stiffness, tightness, tingling, numbness or pain (burning, sharp, shooting, deep ache, dull ache, soreness etc.)



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AUTHROZATION FOR TREATMENT

I do hereby agree and give my consent for ***Art of Health Physical Therapy, PC*** to perform a physical therapy evaluation and/or rehabilitative treatment. Treatment and care may include but not limited to manual therapy (i.e. myofascial release, soft tissue mobilization, connective tissue mobilization, trigger point release, visceral mobilization, cranio-sacral therapy), therapeutic exercises, balance training, neuro-muscular-re-education and/or client education of posture and body mechanics.
I hereby give authorization for the performance of such rehabilitation procedures as permitted by the New York Statutes under the appropriate scope of practice act, in the judgement of my physical therapist, deemed necessary.
I understand that, as in the practice of medicine, physical therapy treatment may have some risks. I understand that I have the right to ask about these risks and have any of my questions answered prior to treatment.

Patient/Parent/Guardian Signature **Date**

CANCELLATION/NO SHOW/LATE POLICY

Art of Health Physical Therapy, PC has a 24-hour cancellation policy.
I will provide Art of Health Physical Therapy. PC with a written or verbal cancellation no later than 24 hours prior to my scheduled appointment time. If I failed to do so, I will incur a fee of $95. The fee will be waived if the cancellation or no show is the result of an emergency.
If I am late to an appointment or must leave early, I understand that I will be treated only for the remaining time and will be responsible to pay for the whole session.
I have read the above policy and by signing this form, I agree to the cancellation/no show policy of Art of Health Physical Therapy, PC.

Patient/Parent/Guardian Signature **Date**

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PAYMENT POLICY/PATIENT AGREEMENT

Art of Health Physical Therapy, PC is not a contracted health care provider with any insurance companies.
I understand that there may be a possibility that my treatments at Art of Health Physical Therapy, PC may not be reimbursed back to me by my insurance company and that reimbursement is highly dependent on my "out of network" benefits. I acknowledge that it is my responsibility to be informed about the details of my particular insurance plan and that I will pay for the treatment at the time the service is rendered, then submit the bill for reimbursement if I choose to do so.
I agree to pay Art of Health Physical Therapy, PC for the services rendered to me at the course of my treatment. I shall be personally responsible for any unpaid balance to this office. If I do not pay for the charges that are my responsibility, I agree to pay Art of Health Physical Therapy, PC collections costs including attorney and court fees.

Patient/Parent/Guardian Signature **Date**

PRIVACY NOTICE/AUTHORZATION FOR RELEASE OF INFORMATION

I understand that Art of Health Physical Therapy, PC will maintain my privacy to the highest standards.

Photographs taken during the initial evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below, I consent to the use of these photographs in a professional manner.
I agree that Art of Health Physical Therapy. PC may provide information from my medical record to persons involved in my medical care.
I agree that Art of Health Physical Therapy. PC may use or disclose my personal health information for the purposes of carrying out a treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.
I agree that Art of Health Physical Therapy. PC may obtain information from others who have provided medical care to me and/or responsible for the payment of all or part of my bills when this information is needed in order to treat, bill and/or receive payment.
I have read the "Notice of Privacy Practices" mandated by HIPAA.

Patient/Parent/Guardian Signature **Date**

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