The Physical Therapy & Wellness Institute
"Bodies Under Repair"™

Patient Intake & Health History Form

Patient Information

First Name:________________________________ Last Name:_________________________________ Middle Initial:____ Gender: M or F

Address:__________________________________ City: ________________________________ State: ________ Zip Code:_________________

Preferred Phone H/C/Wk: ___________________________ Alternate Phone H/C/Wk: ___________________________

Email Address: ____ Date of Birth:___-___-___ Last 4 SSN: ___________

Marital Status: Single / Married/ Other Age: _________

Additional Questions/Clinical Info

Auto Related: Yes/No **Work Related**: Yes/No **Accident Related**: Yes/No

Body Part: ______________ **Right or Left** **Date of Injury**: _______ **Mechanism Of Injury**: ______________

Have you had diagnostic tests performed for this injury: Y/N **MRI**: Y/N **X-Ray**: Y/N

Where were they performed: _________________

Are you currently receiving home health care services? Y/N
Name of Agency:___________________________
If Yes, what type of home health care services: _________________________
Last date of service: ________

Have you received PT, OT or Speech therapy services since the first of the year? Yes/No

Clinical Information:

MIPS **Height:**
Weight:
BMI: __________

MIPS **Have you fallen in the past 6 months?**

MIPS **Pain**
Area of body:

Current 0-10: ____
At worst: 0-10: ___
At best: 0-10 ___

My Goals in coming to Physical Therapy are:

To Get rid of my Pain _____
To Get Stronger _____
To Improve Range of motion ______
Other: ____
To Improve Sports Performance: _____
To Improve my Work abilities: _____
To get better with my home activities _____
To Improve function around the house _____

Emergency Contact

Contact Name: ____________________________ Relationship to Patient: _________________________ Phone Number: _____________________

If patient is a minor: Guardian: ____________________________________ Phone Number: _____________________________________

Physician Information

Name of Referring Physician: _________________________________ Name of the 1st Doctor you saw for this onset?: __________________________

Family Physician: ____ Phone Number: __________________________

Do you have a scheduled return date to see the referring doctor? Y / N. **If yes**, when are you scheduled to return to the doctor? ___________________

Employer Information

Employer Name:_______________________________________ Employment Status: ___ Full Time ___ Part Time ___ Retired ___ Student

Employer Address: _____________________________________ City: ___________________________ State: _____ Zip Code: ___________

Work Phone Number: _____________________ Patient Occupation: ____________________________________ Modified Duty: Y/N

How did you hear about us?

My Doctor referred me here ____ Previous Patient ____ Family/Friend ____ Their Name: ____________________________________
Their Address: __________________________________

List Provided by my Doctor ____ Insurance List ____ Mailing Card ___ Home Health Care/Name & Phone # _________________
Worker's Comp Panel ____ Website ____ Other (explain) ____

Medications: (please indicate dose, frequency)

MIPS

Drug:	How often	Dose	How taken?
__Fentanyl	__________	____________	_______________________
__ Duragesic	__________	____________	_______________________
__ Hydrocodone	__________	____________	_______________________
_ Vicodin	__________	____________	_______________________
_ Morphine	__________	____________	_______________________
_ Dilaudid	__________	____________	_______________________
__Tylenol/codeine	__________	____________	_______________________
Other; Please list			
_______________	__________	____________	_______________________
_______________	__________	____________	_______________________
_______________	__________	____________	_______________________
_______________	__________	____________	_______________________
_______________	__________	____________	_______________________

Medical History

	Yes	No		Yes	No
Allergies	☐	☐	Gallbladder Problems	☐	☐
Anemia	☐	☐	Hepatitis	☐	☐
Anxiety	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	Incontinence	☐	☐
Asthma	☐	☐	Kidney Problems	☐	☐
Cancer	☐	☐	Metal Implants	☐	☐
Cardiac Conditions	☐	☐	Multiple Sclerosis	☐	☐
Cardiac Pacemaker	☐	☐	Osteoporosis	☐	☐
Chemical Dependency	☐	☐	Parkinson's	☐	☐
Circulation Problems	☐	☐	Rheumatoid Arthritis	☐	☐
Currently Pregnant	☐	☐	Seizures	☐	☐
Depression	☐	☐	Speech Problems	☐	☐
Diabetes	☐	☐	Strokes	☐	☐
Dizzy Spells	☐	☐	Thyroid Disease	☐	☐
Emphysema/Bronchitis	☐	☐	Tuberculosis	☐	☐
			Other		

I consent to Physical Therapy and Wellness Institute (PTW) for treatments/procedures that are necessary or advisable for my care. I authorize PTW to exchange with and/or release requested information on my medical care to my insurance carrier and any other parties involved in your case.

____ ___________________________

Patient's Signature Date

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due by my insurer to Physical Therapy & Wellness Institute. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information from Physical Therapy & Wellness Institute.

____ ___________________________

Patient's Signature Date

I have read and understood Physical Therapy & Wellness Institute's privacy notice. I further that I may obtain a copy of this privacy notice upon request.

____ ___________________________

Patient's Signature Date

I have read and understand Physical Therapy & Wellness's billing and collection policies, The Financial Policy, cancellation and no show policies. I further understand that I may obtain a copy of this policy upon my request.

____ _____________________

Patient's Signature Date

____ _____________________

Responsible Party's Signature (if patients is a minor) Date

Now the easy stuff:

Patient Agreement:

I agree to attend when scheduled. (Cancellations affect 3 people – Your Therapist, the patients wanting appointments, and your recovery)
I agree to be respectful towards other patient's privacy.
I agree to give good effort in my rehabilitation program.

PTW Agreement:

We agree to have staffing available to attend your needs, treat you with the respect you deserve, and are honored you have chosen us to help
We agree to give you the privacy that you expect.
We agree to provide you with quality Physical Therapy to help you achieve a higher level of performance at *your body repair stop*.