

Southtowns Physical Therapy Group

Patient Intake Form

Name: (Dr.)(Mr.)(Mrs.)(Ms.) _____ Today's Date: ____/____/____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Social Security Number: ____-____-____ Date of Birth: ____/____/____

Employer: _____ Occupation: _____

Address: _____ Currently Working: __ Yes __ No

Person to be notified in case of emergency: _____ (name) _____ (phone number)

Referring Physician: _____ Primary Physician: _____

Have you had previous Physical Therapy within this calendar year? __ YES __ No

If Yes, WHEN, WHERE and for WHAT body part? _____

Are you currently receiving any home health services? (i.e. nursing, therapy, lab tests) __ Yes __ No

Party Responsible for Payment: __ Self __ Personal Insurance __ Workers' Compensation
__ No-Fault __ Other _____

Insurance Information: (please note that it is your responsibility to provide accurate insurance information)

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

Workers' Comp. WCB#: _____ Carrier Case #: _____

Please indicate if any of the following apply to you:

Metal Implants Arthritis Diabetes Pregnant Cancer Pacemaker

I understand that billing of insurance companies is a courtesy, and that I am financially responsible for payment at the time services are rendered. If I do not provide the correct information required for billing, I will be personally responsible for all expenses associated with services rendered. Expenses may include interest charges, collection fees, legal/court costs. I hereby give permission to Southtowns Physical Therapy Group to administer treatment for my condition and authorize Southtowns to release all necessary medical records to parties responsible for payment. I also understand that I may receive Physical Therapy without a prescription from my physician; however, my insurance company may not pay for these services if a prescription is not provided.

Signature: _____ Date: _____

Our billing department will attempt to answer any questions regarding your financial responsibility, however, specific questions pertaining to your contract should be directed to your insurance carrier.

What body part are you here for? (i.e. neck, back, knee, etc.) _____

What kind of problems are you experiencing? (please circle all that apply)

Pain Swelling Weakness Poor Balance Stiffness Walking Numbness _____ Spasm Decreased Motion

When did your symptoms/injury occur? ____/____/____ ___ Gradual (specific date unknown)

How did your symptoms develop?
Work ____ Car Accident ____ Slip/Fall ____ Unknown ____ Other _____

Please describe your injury: _____

Have you had a similar injury before? ____ No ____ YES (if yes, please describe injury, date and any treatment received)

Please rate your pain intensity from 1-10 Currently: ____ Worst: ____ Best: ____

Briefly describe your pain: (i.e. shooting, burning, etc.) _____

Where are your symptoms located? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Do you have any allergies? ____ NO ____ YES (if yes, please list below)

Allergies: _____

What medications are you currently taking: _____

Have you received any previous treatment for this condition? ____ NO ____ YES (if yes, please list below)

Have you undergone any diagnostic testing? ____ NO ____ YES (if yes, please check below and list location/s)

X-Ray CT Scan MRI EMG/NCV Other _____

Location/s: _____

Past Medical History: None YES (briefly describe)

Past Surgical History: None YES (briefly describe)

