PRECISION
Physical Therapy Specialists, PLLC

PHYSICAL THERAPY INTAKE FORM

PATIENT INFORMATION

Full Name: _____ **DOB**: _____ **Age**: _____ **Gender:** _____

Preferred Contact Method: ☐ E-mail ☐ Phone ☐ Text Message

Emergency Contact: _____ **Phone**: _____

Emergency Contact Relationship: _____

Employer: _____ **Occupation:** _____

CURRENT CONDITION

Type of Injury/Condition/Surgery: _____

Date of Injury/Onset: _____

Please describe any activities or movements that aggravate your symptoms or activities that you cannot perform due to this condition:

_____

_____

Please describe any treatments, movements, or self-care that decrease your symptoms:

_____

_____

Please list any previous significant injuries, conditions, or surgeries:

_____

_____

Have you had any of the diagnostic tests in relation to this injury? If yes, please list

_____

Which of the following describes your pain? (check all that apply)

☐ Sharp ☐ Achy ☐ Burning ☐ Tingling ☐ Numbness ☐ Other: _____

Are you currently taking any medications? ☐ Yes ☐ No

Please list all medications and dosages: _____

_____

Please rate your pain on a 0-10 scale over last week: *(0=None, 5=Moderate, 10=Severe)*

At present: _____ At best: _____ At worst: _____

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PATIENT MEDICAL HISTORY

Have you been diagnosed with any of the following conditions? (check all that apply)

☐ Allergies	☐ Diabetes	☐ Metal implants
☐ Anemia	☐ Dizziness/vertigo	☐ Multiple sclerosis
☐ Anxiety	☐ Emphysema/Bronchitis	☐ Neurological disorder
☐ Arthritis	☐ Fibromyalgia/Chronic fatigue	☐ Osteoporosis/Osteopenia
☐ Asthma	☐ Fractures	☐ Pain syndrome/CRPS
☐ Bladder/Bowel problems	☐ Gastrointestinal problems	☐ Parkinson's
☐ Cancer	☐ Gallbladder/Kidney problems	☐ Seizures
☐ Cardiac disease/conditions	☐ Headache/Migraines	☐ Speech problems
☐ Circulation problems	☐ Hepatitis	☐ Strokes
☐ Currently pregnant	☐ High blood pressure	☐ Thyroid problems
☐ Depression	☐ Incontinence	☐ Vision problems

Have you suffered from any illness not listed here? ☐ Yes ☐ No
If yes, please explain: _____
_____

Have you recently experienced any of the following symptoms:

☐ Weight change	☐ Chest pain, palpitations	☐ Change in bowel or bladder function
☐ Fevers	☐ Shortness of breath	☐ Gynecologic problems
☐ Vision changes	☐ Nausea, vomiting	☐ Rash or skin changes
☐ Difficulty swallowing	☐ Black Stools, incontinence	☐ Dizziness, weakness, numbness
☐ Headaches	☐ Night pain	☐ Depression, sleep problems

TREATMENT HISTORY & QUESTIONNAIRE

Have you been treated for this condition before? ☐ Yes ☐ No If yes, by whom? _____

What are your goals for Physical Therapy? _____
_____

Is there anything else that you would like to include or ask your therapist?
_____

HEALTH HABITS & LIFESTYLE

Do you have any exercise/leisure activities that are limited by this condition? ☐ Yes ☐ No
Type: _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____ For how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

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Health Insurance Portability and Accountability Act

I would like to receive notice of my HIPPA rights _____ (initial) or

I waive my right to receive notice of my HIPPA rights ____(initial)

CONSENT FOR CARE AND TREATMENT

Physical therapy involves the use of many different types of physical evaluation and treatment. At Precision Physical Therapy Specialists, PLLC, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

Signature: _____ Date: _____

Print Name: _____

CHAPERONE POLICY FOR MINORS

Precision Physical Therapy Specialists, PLLC asks that all patients under the age of 18 to be accompanied by a parent or chaperone. Treatment for neck and back pain often includes contact around the chest or pelvis. If a minor is not accompanied by an adult, manual therapy approaches so these areas will be deferred and exercise alternatives will be given even if there is potential of the exercise being the less effective option. Adults are also welcome to bring someone to observe their sessions.

Signature: _____ Date: _____

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CANCELLATION AND NO-SHOW POLICY

Precision Physical Therapy Specialists, PLLC requires 24-hour advance cancellation notice of scheduled appointments. As a small company, we have limited scheduling staff, making last minute openings in the schedule difficult to fill. Cancellations, absent a compelling reason (i.e., family emergency, illness) that are not cancelled within a 24-hour time frame will incur a cancellation fee of $50.00. Same day cancellations and no-show appointments will incur a fee of $100.00. Three (3) or more same day cancellations and/or no-shows may result in discharge from therapy services at Precision Physical Therapy Specialists, PLLC.

Signature: _____ Date: _____