ProKinetics
PHYSICAL THERAPY

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

Patient Name: *Last :*_____*First:*_____*MI:*_____

SS#_____-_____-_____**Date of Birth:**____/____/_____ **Email Address:**_____

Age: _____ **Gender:** (circle one) Male / Female **Marital Status:** (circle one) Single / Married / Divorced

Address:_____*Apt#*_____*City:*_____*State:*_____*Zip:*_____

Phone #: *Home:*_____*Cell:*_____*Work:*_____

Employment Status: (circle one) Full Time / Part-Time / Retired / Unemployed / Student F/T / Student P/T

Employer/School Name:_____**Employer Address:**_____

Referring by:_____ **Date of Injury:**_____ **Date of Surgery:**_____

Is your condition related to: (circle one) **EMPLOYMENT:** YES / NO (circle one) **AUTO ACCIDENT:** YES / NO

Have you been to another outpatient Physical Therapy facility this year? (circle one) YES / NO

Are you currently receiving Home Care? (circle one) YES / NO

EMERGENY CONTACT

Name: *Last:*_____ *First:*_____ **Relationship to Patient:**_____

Home Phone #: (_____) _____ - _____ **Cell Phone#: (**_____) _____ - _____

Legal Guardian Name: (If patient under 21) *Last:*_____ *First:*_____

Home Phone #: (_____)_____ - _____**Cell Phone#** (_____)_____ - _____

INSURANCE INFORMATION

Primary Insurance

Company Name: _____ **Phone #:** (____) _____ - _____

Policy Holder Name (If other than Patient): *Last:* _____*First:*_____

Policy Holder's SS# _____-_____-_____ **Policy Holder's Date of Birth:** _____/_____/_____

Policy Holder's Address:_____ **Relationship to Patient:**_____

Secondary Insurance

Company Name: _____ **Phone #:** (____) _____ - _____

Policy Holder Name (If other than Patient): *Last:* _____*First:*_____

Policy Holder's SS# _____-_____-_____ **Policy Holder's Date of Birth:** _____/_____/_____

Policy Holder's Address:_____ **Relationship to Patient:**_____

Reason for today's visit:_____

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MEDICAL HISTORY QUESTIONAIRRE Please complete this form to help us better understand your medical history. Once this is filled out it will become part of your medical records.

Patient Name_____ **DOB**_____ **Age**_____

Referring Physician_____**Primary Physician**_____**Last Health Check-Up**_____

Did you have surgery for this injury? YES / NO **Name of surgery:**_____**Date**_____

Please circle the number that would best describe your pain ☺ **0 1 2 3 4 5 6 7 8 9 10** ☹

My pain can be described as (Please circle all that apply)

Constant Intermittent Sharp Dull Aching Stabbing Stiff Numbness Pins/Needles

Are you currently taking prescription or non-prescription medication? (Please List) _____

_____

Have you had any Medical/Rehabilitative Care for this Injury/Episode?

CHIROPRACTIC	YES	NO	CT SCAN	YES	NO
GENERAL PRACTITIONER	YES	NO	X-RAY	YES	NO
OCCUPATIONAL THERAPY	YES	NO	MRI	YES	NO
MASSAGE THERAPY	YES	NO	ER CARE	YES	NO
ORTHOPEDIST	YES	NO	EMG/NVC	YES	NO
NEUROLOGIST	YES	NO	MYELOGRAM	YES	NO
OBSTETRICIAN/GYNECOLOGIST	YES	NO	PODIATRIST	YES	NO
PEDIATRICIAN	YES	NO	Acupuncturist	YES	NO

Do you now have or have you ever had any of the following conditions?

ASTHMA/BRONCHITIS/EMPHYSEMA	YES	NO	SEVERE OR FREQUENT HEADACHES	YES	NO
SHORTNESS OF BREATH/CHEST PAIN	YES	NO	VISION OR HEARING DIFFICULTY	YES	NO
CORONARY HEART DISEASE OR ANGINA	YES	NO	NUMBNESS OR TINGLING	YES	NO
PACEMAKER	YES	NO	DIZZINESS OR FAINTING	YES	NO
HIGH BLOOD PRESSURE	YES	NO	WEAKNESS	YES	NO
HEART ATTACK/HEART SURGERY	YES	NO	WEIGHT LOSS/ENERGY LOSS	YES	NO
BLOOD CLOT/EMBOLI	YES	NO	HERNIA	YES	NO
STROKE/TIA Date:____/____/____	YES	NO	EPILEZPSY SEIZURES	YES	NO
ALLERGIES	YES	NO	THYROID TROUBLE/GOITER	YES	NO
DIABETES	YES	NO	URINE INCONTINENCE	YES	NO
INFECTIOUS DISEASE	YES	NO	FECAL INCONTINENCE	YES	NO
CANCER Type_____	YES	NO	BOWEL/BLADDER PROBLEMS	YES	NO
CHEMO/RADIATION Date:____/___/___	YES	NO	SLEEPING PROBLEMS	YES	NO
OSTEOPEROSIS	YES	NO	DO YOU SMOKE?	YES	NO
LATEX ALLERGY	YES	NO	NECK INJURY/SURGERY	YES	NO
LATEX SENSITIVITY	YES	NO	SHOULDER INJURY/SURGERY	YES	NO
ARTHRITIS/SWOLLEN JOINTS	YES	NO	ELBOW/HAND INJURY/SURGERY	YES	NO
MULTIPE SCLEROSIS	YES	NO	BACK INJURY/SURGERY	YES	NO
JOINT REPLACEMENT Date: ___/___/___	YES	NO	KNEE INJURY/SURGERY	YES	NO
PINS/METAL IMPLANTS:_____	YES	NO	LEG/ANKLE/FOOT INJURY/SURGERY	YES	NO

WOMEN ONLY

ARE YOU PREGNANT?	YES	NO	URINE/FECAL INCONTINENCE	YES	NO
COMPLICATED PREGNANCY/DELIVERY	YES	NO	PROLAPSE Type:_____	YES	NO
PELVIC INFLAMMATORY DISEASE	YES	NO	ENDOMETRIOSIS	YES	NO
IRREGULAR MENSTRUAL CYCLE	YES	NO	DIASTISIS RECTI	YES	NO

Patient Signature:_____ **Date:**____/____/_____

Guardian Signature:_____**Date:**____/____/_____

Physical Therapist Signature:_____**Date:**____/____/_____

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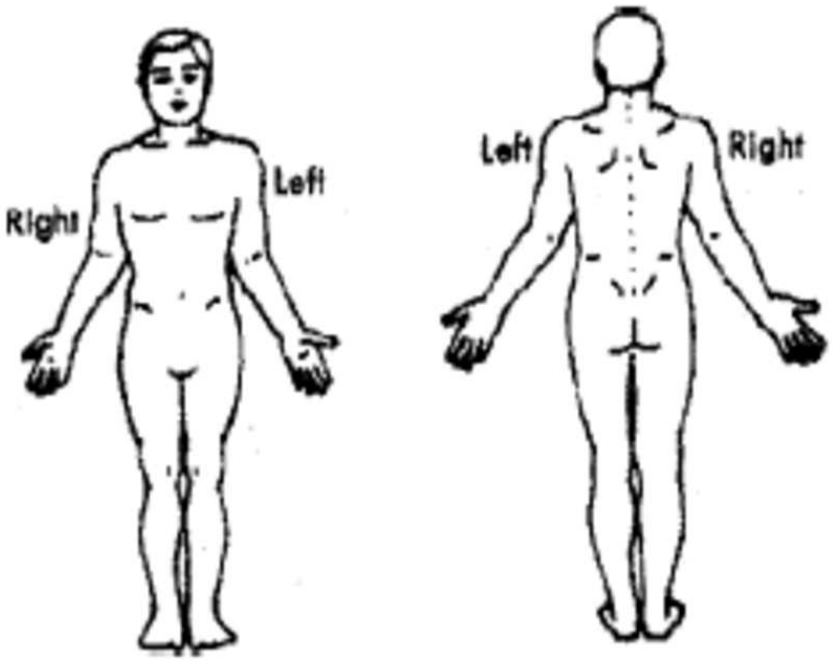
BODY PAIN SCALE

Pain Rating Scale: Use the number scale that is listed below to describe the INTENSITY of your pain.

NO PAIN	LOW			MEDIUM			HIGH			SEVERE
0	1	2	3	4	5	6	7	8	9	10

Using the number rating system above, describe your:

	Pain level NOW:		(0-10)
In the past 30 days	Pain level at BEST:		(0-10)
In the past 30 days	Pain level at WORST:		(0-10)



Use the symbols listed below to describe the location and type of pain or unusual feelings you are having by drawing them on the picture(s) above.

OOOO	Pins and Needles
XXXX	Numbness
//////	Pain
====	Other

Patient Signature: _____ Date: _____
(Parent or Guardian if patient is a minor)

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NOTICE OF PATIENT PRIVACY / HIPAA AWARENESS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

With my permission, ProKinetics Physical Therapy may use and disclose protected health information (PHI) about me for the purposed of carrying out treatment, payment, and health care operations (TPO). *I have the right to review any of my physical therapy records with 24 hour notice. Written consent is required for patient copies of medical records. Copy rate: $0.30/page.*

Treatment Includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians, and other physical therapists. For example: we may feel that a patient who we are treating for a Stroke would benefit from an evaluation by a speech language pathologist to assess swallowing difficulty. The health information we share with this speech language pathologist would be considered a treatment related disclosure.

Payment Includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so that payment can be obtained for services rendered. Your insurance company may make a request to review your medical records to determine that your care was necessary.

Health Care Operations Includes the utilization of your records to monitor the quality of care being given at the ProKinetics Physical Therapy facility or for business planning activities.

Other Special Uses ProKinetics Physical Therapy may use your PHI to send you an appointment reminder, to inform you of our health related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law The federal health information privacy regulations either permit or require ProKinetics Physical Therapy to use or disclose your PHI in the following ways we may share some of your PHI with a family member or friend involved in your case if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court ordered subpoena. Disclosures to health agencies are sometimes required by law to report communicable disease or adverse drug reactions. We may use and disclose health information about you to prevent a serious threat to your health or safety or the health of the public or others. If you are in the armed forces we may release health information about you when it is determined to be necessary by the appropriate military command authorities. ProKinetics Physical Therapy may also release information about you for worker's compensation or other similar programs that provide benefits for work-related injury or illness. Your authorization is required before your PHI may be used or disclosed by us for other purposes.

With my permission, the office of ProKinetics Physical Therapy may send mail items marked "confidential" or "private" to my home or other designated locations, email items, or call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, patient statements, and any call pertaining to my clinical care, including imaging results among others.

I have the right to request that ProKinetics Physical Therapy restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian_____

Print Patient's Name_____**Date**_____

Print Name of Legal Guardian_____

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PATIENT RESPONSIBILTY FORM

Welcome to ProKinetics Physical Therapy. Thank you for choosing this facility for your rehabilitation. We look forward to serving you with the highest quality of care available. Please take the time to read the important information below.

SCHEDULING Our treatment sessions are by appointment only. You are responsible for scheduling your appointments in advance. Additionally we do not have appointment times for patients indefinitely as we allot a certain amount of time for each patient appointment to assure to best quality of care is provided.

CANCELLATION It is understandable that life gets in the way sometimes but if you are unable to attend a scheduled physical therapy treatment session, please give at least 24hrs. notice prior to your appointment time. Prior notice can be given via telephone or email.

PAYMENT If treatments, certain procedures that are part of your treatment, or supplies are not covered by you insurance, or your coverage requires co-payment for services payment is expected on the date of each treatment session in the form of cash or check. In addition, if your insurance company does not provide payment within 90 days from the date of service, and a reasonable attempt has been made by ProKinetics Physical Therapy to collect payment from them, then you will be billed for the services. Other payment arrangements may be considered upon prior approval.

PATIENT PARTICIPATION It is ProKinetics Physical Therapy's responsibility to provide you with first-rate care, and to educate you concerning proper exercise and health principals. In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

NO WARRANTY I recognize that the practice of physical therapy is as much an art as a science, and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcome of any therapy. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

IFORMED CONSENT The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

POTENTIAL RISKS: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist.

POTENTIAL BENEFITS: I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain

Authorization of Treatment, Assignment of Insurance Benefits, and Guarantee of Payment I consent to the treatment which my physical therapist deems necessary. I understand that in order to evaluate my condition it may be necessary for my pelvic floor to be examined as part of my initial evaluation and periodically throughout treatment. (For Women's/Pelvic Health Patients ONLY) I hereby guarantee payment of all charges incurred for my course of treatment. I understand that I must pat any copayment, co-insurance, or deductible due at the time of service. I understand that certain procedures and supplies may not be covered by my insurance and I will be responsible for those payments while ProKinetics Physical Therapy will verify my benefits. I agree that it is ultimately my responsibility to know what is covered and what is not covered by my insurance plan. I further agree to pay, upon receipt, any bill from ProKinetics Physical Therapy P.C. for services or products not covered by my insurance.

Print Patient or Guardian Name_____

Signature_____ Date_____

Patient's Authorization to Release Medical Information

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996, (HIPPA), in order for your healthcare provider or staff of *ProKinetics Physical Therapy P.C.,* to discuss your medical condition or billing information with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so.

In accordance with the above, I _____,
Date of Birth:_____SSN:_____,
hereby authorize *ProKinetics Physical Therapy P.C.* to discuss with and release my medical and/or billing information to the following individuals:

_____	_____	_____
Name	Relationship	Phone#
_____	_____	_____
Name	Relationship	Phone#
_____	_____	_____
Name	Relationship	Phone#
_____	_____	_____
Name	Relationship	Phone#

Furthermore, I understand that if there is any information in my medical record I do *not* want discussed with or released to the above, I must designate it here by stating what information is to be excluded:_____

_____

_____

_____I do **NOT** give my permission to *ProKinetics Physical Therapy P.C.* to release or discuss my medical, billing, or any other information with any family members.

Please Print
Patients Name:_____
Patient Signature: _____Date:_____
Witness:_____Date