

**COMMUNITY SPORTS AND THERAPY CENTER**

***Patient Intake Form***

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

Are you presently receiving any health care services from a home health agency such as Community Hospital Home Health or Celina Visiting Nurses?

Yes \_\_\_\_\_ No \_\_\_\_\_

Are you presently receiving any health care services from hospice?

Yes \_\_\_\_\_ No \_\_\_\_\_

What diagnosis/injury has brought you to therapy? \_\_\_\_\_

\_\_\_\_\_

When did it start? \_\_\_\_\_

Current and Past Medical History (Check all that apply.)

- |                                                  |                                                 |                                             |
|--------------------------------------------------|-------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Heart disease           | <input type="checkbox"/> Back problems          | <input type="checkbox"/> Pacemaker          |
| <input type="checkbox"/> Low/High blood pressure | <input type="checkbox"/> Neck problems          | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Heart attacks           | <input type="checkbox"/> Mental health problems | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Skin diseases          | <input type="checkbox"/> Surgeries** (List) |
| <input type="checkbox"/> Fractures               | <input type="checkbox"/> Contagious diseases    | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Emphysema/asthma        | <input type="checkbox"/> Active TB              | <input type="checkbox"/> Other              |

If you checked any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_

Are you currently being treated by another physician or health care practitioner (chiropractor, physical therapist, etc)? Yes \_\_\_ No \_\_\_ If yes, who? \_\_\_\_\_

For what? \_\_\_\_\_

\_\_\_\_\_

Please check any of the following treatments you have had and in the space provided, respond to whether it helped or did not help.

<input type="checkbox"/> Physical therapy _____	<input type="checkbox"/> Psychologist _____
<input type="checkbox"/> Occupational therapy _____	<input type="checkbox"/> Chiropractor _____
<input type="checkbox"/> Pain program _____	<input type="checkbox"/> Nerve block _____
<input type="checkbox"/> Back school _____	<input type="checkbox"/> TENS _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Please check what learning style you prefer:

Verbal instructions       Doing the activity       Reading information  
 Other \_\_\_\_\_

Is your ability to learn limited by any of the below conditions?

<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Visual impairment	<input type="checkbox"/> Do not speak English
<input type="checkbox"/> Do not read well	<input type="checkbox"/> Anxiety attacks	<input type="checkbox"/> Lack of motivation
<input type="checkbox"/> Memory problems	<input type="checkbox"/> No limitations	

Do you have any religious or cultural considerations we need to know about before you start our program? Yes  No  If yes please explain: \_\_\_\_\_

Are you in a situation with someone who is physically, emotionally, or sexually hurting you? Yes  No

(Females only) Is there a possibility that you are pregnant?  Yes  No  N/A

\*\*\*Please feel free to ask our staff any questions you may have regarding our services or any billing/price information. We will be glad to assist you in any way we can.

**Several insurance companies require you to contact them before you receive treatment even though you have a physician's prescription for therapy. It is your responsibility to see that this is done but our staff will assist you as much as possible. Insurance coverage varies from company to company. It is the patient's ultimate responsibility to verify insurance coverage for services received.**

**\*\*Our goal is to provide you with the highest quality professional service in an efficient manner. We have allocated sufficient time to properly meet your needs. If for any reason you cannot make your therapy appointment, please notify us at least 8 hours before the scheduled the scheduled appointment. If you fail to do so, we reserve the right to charge a missed appointment charge that insurance usually doesn't cover.**

**\*\*I, the patient have reviewed the Rehabilitative Services Department's Patient Bill of Rights and Responsibilities statement and I am committed to cooperating and participating at my fullest capacity. A copy of the hospital Patient Bill of Rights and Responsibilities (Policy #A-3) that addresses all the rights and responsibilities of patients is also available upon request.**

\_\_\_\_\_  
Patient signature/Parent or Guardian signature  
(if patient is minor parent must sign)

\_\_\_\_\_  
Therapist signature

We are a clinical education site for multiple universities and professional schools. There are times we have therapy students in our department. They may observe and at times perform your treatment program in aspects of your care that they have been determined to be competent in and with proper supervision. May we have your permission for students to perform and/or observe your treatment? If at any time you feel uncomfortable with this you may let us know and we will make other arrangements.

Yes \_\_\_ Students may perform, participate and/or observe my treatment with proper supervision.  
No \_\_\_ Students may not perform and/or observe my treatment.

There are also volunteers in our department observing this field of the medical environment in further medical education. Volunteers by policy do not perform treatment in our department.

Yes \_\_\_ Volunteers may observe my treatment.  
No \_\_\_ Volunteers may not observe my treatment.

How did you hear about us? Please circle all that apply: Doctor    Newspaper Ad    Web site  
Radio Ad    Friend/Relative    Had previous experience here    Other \_\_\_\_\_

**ARE YOU EXPERIENCING ANY PAIN RELATED TO THIS**

**INJURY/DIAGNOSIS:**    \_\_\_ Yes    \_\_\_ No    \_\_\_ N/A

**\*\*\*If you answered yes to the above question please continue on to the next page and complete the pain questionnaire prior to seeing the therapist.\*\*\***

**PLEASE DO NOT ANSWER BELOW THIS POINT. FOR THERAPISTS USE ONLY.**

Have any special tests been performed or scheduled related to the condition? Yes \_\_\_\_\_ No \_\_\_\_\_

History of illness: \_\_\_\_\_

Previous level of function prior to onset: \_\_\_\_\_

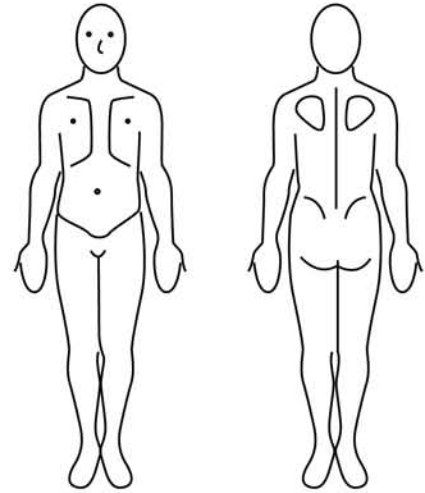
Goals patient wants to achieve: 1) \_\_\_\_\_ 2) \_\_\_\_\_  
3) \_\_\_\_\_ 4) \_\_\_\_\_

Has the therapist discussed the previous information with the patient? \_\_\_\_\_ Yes \_\_\_\_\_ No

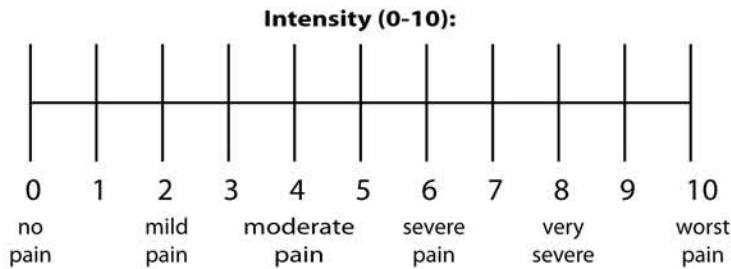
**COMMUNITY SPORTS AND THERAPY CENTER**

**Pain Questionnaire**

1. Please shade in the area where you feel pain:



2. Circle the number that currently describes your pain?



3. How long have you had the pain indicated on the diagram? \_\_\_\_\_

4. What helps relieve your pain?

- heat                       activity                       frequently changing positions
- ice                               rest                               standing
- medication:(name) \_\_\_\_\_
- other: \_\_\_\_\_

5. What makes your pain worse? \_\_\_\_\_

6. Since your diagnosis/injury, check the activities that are painful/difficult:

- bed mobility     positional changes     turning/twisting     sitting
- standing         shopping/banking     yard work             meal prep
- housekeeping     driving/car riding

7. How long can you sleep without pain?

- 8+ hours     6-8 hours     4-6 hours     3-4 hours     1-2 hours

Comments: \_\_\_\_\_

Therapist signature: \_\_\_\_\_ Date: \_\_\_\_\_

# AM I COVERED?

Community Sports and Therapy realizes that navigating through your insurance can be confusing and difficult. As our various paperwork has explained it is the *patient's* responsibility to check your therapy benefits with your insurance company. We have created this form to try to make it easier for you to find out your therapy benefits and know what questions you need to ask. Please share any information you find out with your therapy staff so they will better be able to assist you with following your insurance guidelines while still getting your maximum benefit from therapy.

\*\*\*When calling document the date called and write down the full name of the person you spoke with at that time.

Date: \_\_\_\_\_

Full name of contact: \_\_\_\_\_

Phone number called: \_\_\_\_\_

Questions	Please circle answer	
Is Community Sports and Therapy Center in your network? (We may be listed under varied names with your insurance ie. Mercer Health, Mercer County Community Hospital, Community Sports and Therapy. All billing is completed through the hospital. Our tax ID # is 34-1101385. You can use this to help with the insurance identification.	Yes	No
Is physical/occupational/speech therapy covered?	Yes	No
Is there a limit on the number of visits you can have? If so is the limit .....	Yes Per year?	No Per incident/diagnosis?
Do you need precertification? If <b>yes</b> who needs to do it.....	Yes Doctor?	No Therapist?
Do I have a deductible that must be met before coverage kicks in?	Yes	No
Do I have a copay?	Yes	No
Are there any treatments that are routinely not covered? (These are options that may or may not be chosen by your therapist.) -Iontophoresis (Code 97033) -Phonophoresis (97035) -Electrical stimulation (97014) -Aquatics (97113/97150) -Massage (97124) -Manual therapy (97140)	Yes  Covered Covered Covered Covered Covered Covered	No  Not covered Not covered Not covered Not covered Not covered Not covered

***Please keep in mind that any payment issues are between you and your insurance company. This form is only to assist you to find out your benefits. Payment is ultimately your responsibility.***