New Patient Intake Form

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Email Address: _____

Are you presently receiving ANY type of home health care services from ANY home health agency, examples: Mercer Health Home Health or Celina Visiting Nurses? □ Yes □ No

Are you presently receiving ANY health care services from hospice? □ Yes □ No

Have you received ANY other therapy services in the last year from another therapy agency? □ Yes □ No

What diagnosis/injury has brought you to therapy? _____

_____

Date of Injury/When did it start? _____

What is your goal(s) to accomplish in therapy? _____

_____

Are You Currently Employed? □ Retired/Not working □ Off Work, Last Day Worked: _____
□ Yes, Full Time, No Restrictions □ Yes, Full Time, With Restrictions

Is This a Work-Related Injury? □ Yes □ No If yes, do you have legal representation? □ Yes □ No

Employer Name: _____ Employer Contact Name: _____

Contact Phone Number: _____ Fax: _____ Email: _____

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

For what? _____

List all surgeries/precautions: _____

_____

Do you have any allergies? □ Yes □ No If yes, please list: _____

If you are obtaining therapy without a physician referral, please list a physician in which we can share your therapy information/notes.

Physician: _____

** **Medicare Patients** – in order to bill Medicare, we require a physician referral due to physician certification and recertification requirements by Medicare. **

Patient Name: _____ Date: _____

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

☐ Anemia	☐ COPD/Emphysema	☐ HIV/AIDS	☐ Osteoporosis/Osteopenia
☐ Angina/Chest Pain	☐ Dementia/Alzheimer's	☐ Hyperthyroidism	☐ Pacemaker
☐ Arrhythmia	☐ Depression/PTSD	☐ Hypothyroidism	☐ Parkinson's Disease
☐ Arthritis	☐ Diabetes	☐ Kidney Disease	☐ Renal Disease
☐ Asthma	☐ Drug/Alcohol Abuse	☐ Liver Disease	☐ Seizures
☐ Bleeding Disorder	☐ Fractures	☐ Mental Health Issues	☐ Sickle Cell
☐ Blood Clots	☐ GERD	☐ MI/Heart Attack	☐ Smoker (Current)
☐ CAD (Coronary Heart Disease)	☐ Glaucoma	☐ Migraines/Headaches	☐ Stroke/CVA/TIA
☐ Cancer	☐ Hepatitis	☐ Neurological Diseases	☐ Unexplained Weight Loss
☐ CHF (Congestive Heart Failure)	☐ High Blood Pressure	☐ Obstructive Sleep Apnea	☐ Unusual Fatigue
☐ Congenital Heart Defect	☐ High Cholesterol	☐ Opioid Use (Current)	☐ Vascular Disease

If you checked any of the above, please explain: _____

_____

Please check any of the following treatments you have had in the past.

☐ Physical therapy _____ ☐ Psychologist _____

☐ Occupational therapy _____ ☐ Chiropractor _____

☐ Pain program _____ ☐ Nerve block _____

☐ Back school _____ ☐ TENS _____

☐ 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?

☐ Hearing impairment	☐ Visual impairment	☐ Lack of motivation
☐ Do not read well	☐ Anxiety attacks	☐ No limitations
☐ Memory problems	☐ Do not speak English	

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

Has there been a major change in your life (loss of loved one, loss of job), or in the past few weeks, have you felt down, depressed, or hopeless? ☐ Yes ☐ No

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

Patient Name: _____ Date: _____

** 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 therapy services. 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. Please note that we are a hospital-based facility, not a free-standing facility, and our billing at all locations is completed through Mercer Health hospital.

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 appointment. If you fail to do so, we reserve the right to charge a missed appointment charge that insurance usually does not cover.

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.**
□ **Yes, students may observe and participate in my treatment, but not perform any treatment.**
□ **No, students may not perform, participate 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? *(Check all that apply.)*

□ Doctor □ Newspaper Ad □ Radio Ad □ Social Media

□ Friend/Relative □ Website/Internet □ Previous Experience

□ Other: _____

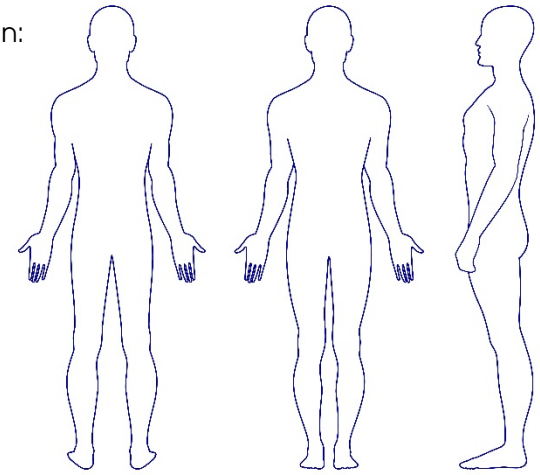
TO THE BEST OF MY KNOWLEDGE, INFORMATION PROVIDED HEREIN IS CORRECT.
I, the patient, have also reviewed the Rehabilitative Services Department's Patient Bill of Rights and Responsibilities statement and I am committed to cooperating and participating at my fullest capacity. A copy of the hospital Patient Bill of Rights and Responsibilities (Policy #A-3) that addresses the rights and responsibilities of patients is also available upon request.

_____ _____
Signature of Patient/Legal Guardian Date

Pain Questionnaire

Patient Name: _____ Date: _____

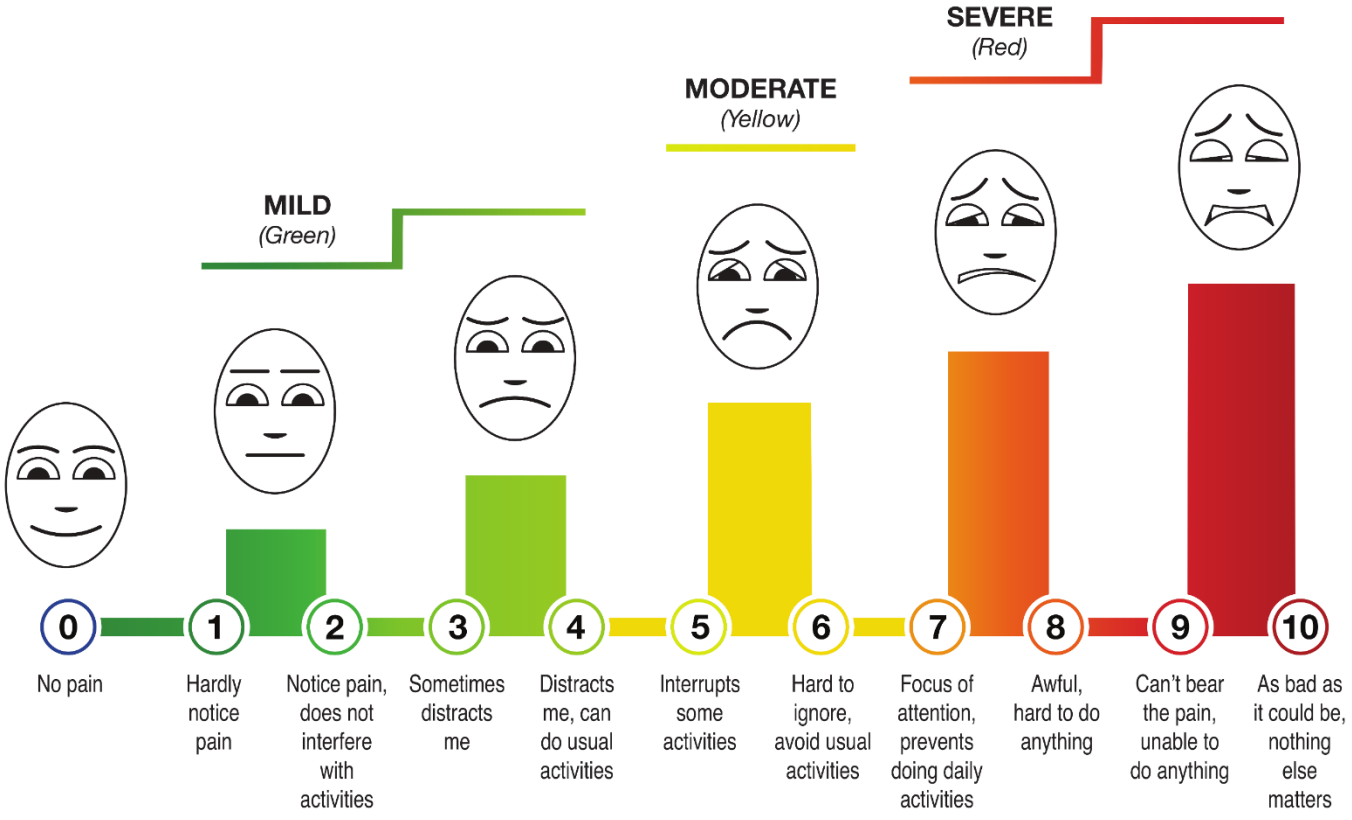
1. Please shade in the area on the body where you feel your pain:



2. Using the ***pain scale below*** what is the number that describes your pain level at **rest**? _____

3. Using the ***pain scale below*** what is the number that describes your pain level with **activity**? _____

Defense and Veterans Pain Rating Scale



4. Does your pain radiate? If yes, where? _____

5. Which describes your pain?

☐ aching ☐ burning ☐ cramping ☐ dull ☐ sharp ☐ shooting ☐ soreness

☐ spasm ☐ stabbing ☐ throbbing ☐ tightness ☐ tingling ☐ other: _____

6. What makes your pain **worse**?

☐ activity ☐ cold weather ☐ anxiety ☐ exertion, physical ☐ inactivity ☐ movement

☐ positioning ☐ other: _____

7. What helps **relieve** your pain?

☐ heat ☐ activity ☐ frequently changing positions ☐ ice ☐ rest ☐ standing

☐ medication (name): _____

☐ other: _____

8. What is a comfortable/acceptable pain level??_____

9. How long can you sleep without pain?

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

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Informed Consent for Physical, Occupational and Speech Therapy

Physical, occupational and speech therapy involve the use of many different types of physical examination and treatment. At Community Sports and Therapy Center we use a variety of procedures and modalities to help us attempt to improve your function. As with all forms of medical treatment, there are benefits and risks involved with therapy.

The physical response to a specific treatment can vary widely from person to person. It is not always possible to predict your response to a certain procedure or modality. We are not able to guarantee what your reaction will be to a particular treatment, nor can we guarantee that our treatment will help the condition you are seeking treatment for.

Benefits may include improvement in symptoms and overall function. You might also experience decreased pain and discomfort. You could also gain a greater knowledge about your condition and how to manage your condition.

Potential risks may include increase in current level of pain, aggravation of previously existing conditions, and could involve life threatening situations.

I understand that the physical therapist, occupational therapist and/or speech language pathologist provides a wide range of services. I acknowledge that my treatment program has been explained and that I have been given an opportunity to ask questions. I understand the risks associated with a program of physical, occupational, and/or speech therapy. I confirm that I have read and fully understand this consent form. I wish to proceed with all therapy services.

_____ _____

Name of Patient (Printed) Date

_____

Signature of Patient/Legal Guardian

I hereby certify that I have explained the proposed evaluation and treatment. I have offered to answer questions. I believe that the patient/guardian understands what I have explained and answered.

_____ _____

Therapist Signature Date

Medical Information Release

In order for our staff to discuss your medical care (or your child's medical care) with someone other than yourself (including a spouse or other family member) we must have your consent. If you know of anyone that may be requesting your (or your child's) medical information from our office (not including another physician or clinic) please give your consent below. By signing this you are releasing the staff of Community Sports and Therapy Center from any and all liability for fulfilling this authorization request.

I hereby authorize the staff of Community Sports and Therapy Center to disclose information related to my (or my child's) current episode of care to the person's listed below:

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

This authorization will expire upon me (or my child) being discharged from this episode of care.

_____ _____
Name of Patient (Printed) Date of Birth

_____ _____
Name of Parent/Legal Guardian, if applicable (Printed) Relationship to Patient

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Witness Date

Authorization is valid from the date of signature or until we receive written notification from you. I understand that I may revoke this authorization in writing at any time.

Date Revoked: _____ **Time:** _____ **Signature:** _____
Patient or Parent/Legal Guardian