# Patient Intake Questionnaire

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ SSN: _____

Email Address: _____

***By providing your e-mail address, you expressly consent to receive e-mails from us. We do not provide or sell your address 3rd party.**

Marital Status: S M D W Sex: M F Former Patient: Yes No

How did you hear about us? _____

Patient Employer: _____

Occupation: _____ Full Time/Part Time: _____

Employer Address: _____ Phone: _____

Emergency Contact Name: _____Phone: _____

Relationship to Patient: _____

Referring Physician: _____ Phone: _____

Address: _____

If you are a Medicare patient, have you been involved in a home health episode? Yes No
(Nursing or Therapy Care in your home – Discharge Date: _____)

Is this treatment due to injuries sustained in an accident (Auto, Work, or Wrongful Injury)? Yes No

If related to accident, what type of accident? ☐ Employment ☐ Motor Vehicle ☐ Personal Injury Claim (Wrongful Physical Injury)

Date and City/State of Accident: _____

Is this treatment covered by any other payer than your personal insurance? Yes No

If yes, who? _____

Are you represented by an attorney? Yes No

If yes, Attorney name: _____ Attorney Phone: _____

# Patient Intake Questionnaire

## Auto/3rd Party Information

Were you or another party at fault? _____ Date of Accident _____

Name and address of other party_____

**Patient** Auto Insurance Company _____ Claim # _____

Claims Mailing Address: _____

Insured's Name: _____

**Other** party Auto Insurance Company _____ Claim # _____

Claims Mailing Address: _____

Insured's Name: _____

Has the accident been reported? Yes No Is there a police report? Yes No

## Workers Compensation

Employer's Name: _____ Employer Ph: _____

City/State where injury occurred? _____

Insurance Company: _____ Claim #: _____

Adjuster Name: _____ Phone #: _____

Address: _____ Fax #: _____

Case Manger Name: _____ Phone #: _____

Address: _____ __ Fax #: _____

Are you currently working full duty? Yes No

## Private Insurance

Primary Insurance Company: _____

Name of Policy Holder? _____ Date of Birth _____

Relationship to Patient _____

Policy Holder Employer: _____

ID # _____ Group #: _____

Secondary Insurance Company: _____

Name of Policy Holder? _____ Date of Birth _____

Relationship to Patient _____

Policy Holder Employer: _____

ID # _____ Group #: _____

# Medication List

| **Patient Information** | |
|---|---|
| Patient Name: | Date of Birth: |
| Date of Service: | |

**Medication List**- **A current list provided by the referring physician or patient containing the below information can be copied and placed behind this list.**

| Name | Dosage | Frequency | Route (method taken) |
|---|---|---|---|
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Patient Signature: _____Date:_____

**Name** _____ **Date of Birth** _____ **Date**_____

**Height:** _____ **Weight:** _____ **MD Follow up Date:** _____

What is your reason for coming to therapy today? _____

Date of injury or when problem began? _____

How did your problem start? ☐ Lifting ☐ Twisting ☐ Falling ☐ Motor vehicle accident ☐ Bending

Describe: _____

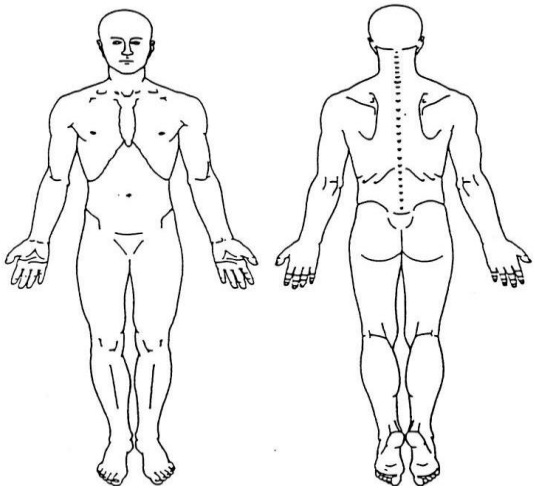
What type of hobbies / activities /exercise did you regularly perform (prior to injury) and how often? _____

_____

Have you had any diagnostic tests (x-ray, MRI, CT scan, etc)? _____

_____

Please mark the location of your pain on the chart below.



Pain at **LOWEST**: Rate your lowest pain level in past week

0 = No pain 10 = Worst pain imaginable

0 _____

0 1 2 3 4 5 6 7 8 9 10

Pain at **WORST**: Rate your highest pain level in past week.

0 = No pain 10 = Worst pain imaginable

0 _____

0 1 2 3 4 5 6 7 8 9 10

Pain **CURRENTLY**: Rate your level of pain at this time.

0 = No pain 10 = Worst pain imaginable

0 _____

0 1 2 3 4 5 6 7 8 9 10

What makes your pain better? _____ What makes your pain worse? _____

Please **CIRCLE** the areas where you have seen a **DECLINE** in your abilities with your most recent condition.

| | | | | |
|---|---|---|---|---|
| ☐ Working | ☐ Lifting | ☐ Kneeling | ☐ Sleeping / Resting | ☐ Dressing / Grooming |
| ☐ Sitting | ☐ Carrying | ☐ Gripping | ☐ Getting in / out of bed | ☐ Balance |
| ☐ Standing | ☐ Bending | ☐ Turning head / trunk | ☐ Lying Down | ☐ Exercise Routine |
| ☐ Walking | ☐ Squatting | ☐ Driving | ☐ Rising from sitting | ☐ Other _____ |

Does your past medical history include any of the following? (**Circle all that apply**)

| | | | |
|---|---|---|---|
| ☐ Cardiac Problems | ☐ High Blood Pressure | ☐ Pacemaker | ☐ Cancer |
| ☐ Fibromyalgia | ☐ Diabetes | ☐ Osteoarthritis | ☐ Rheumatoid Arthritis |
| ☐ Seizures | ☐ Depression | ☐ Asthma | ☐ Orthopedic Problems |
| ☐ GI Problems | ☐ Kidney Problems | ☐ Multiple Sclerosis | ☐ Muscular Dystrophy |
| ☐ Parkinson's Disease | ☐ Drug / Alcohol Dependency | ☐ Infectious Disease | ☐ Autoimmune Disease |
| ☐ Stroke / TIA | ☐ Open Wound | ☐ Brain Injury | ☐ Concussion |
| ☐ Spinal Cord Injury | ☐ COPD | ☐ Lung Disease | ☐ Pregnancy |
| ☐ Urinary Incontinence | ☐ Bowel Incontinence | ☐ Pelvic Pain | |

**BALANCE**

- Have you had two or more falls within the past year? Yes / No
- Have you had one fall resulting in injury within the past year? Yes / No

Please list any major surgeries with dates _____

List allergies (medication, latex, etc)_____

List all medications you are currently taking: ☐ See List attached ☐ None

What are your goals for therapy? _____

**PATIENT SIGNATURE**_____

Revised: 05/23/2019

# Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Patient Name: _____ Case Code: _____

In an effort to comply with HIPAA (Health Insurance Portability Accountability Act) regulations, we need you to complete the following information. Please list any person other than your doctor with whom we may discuss your private health information or financial matters:

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

*I understand I can withdraw the above at any time, with a written request. I also understand that it is my responsibility to ensure that anyone listed above does not disclose or use any of the information without discussing it with me first.

I, the undersigned, hereby consent to receive notifications from ApexNetwork Physical Therapy (hereinafter referred to as "Apex"), which notifications may include my PHI, by the following methods of communication that I indicated below, with a full understanding of the risks involved with such notifications from Apex. I agree to assume all responsibility for informing Apex in writing of any changes to any of the methods of communications that I indicated below and for ensuring that the methods of communication that I indicated below are secure, with password protection used where applicable. I further agree that Apex shall not be held liable for any unauthorized disclosures of my PHI to a third party through any of the methods of communication I authorized below or for any fees and/or restrictions that may be imposed upon me for receiving notifications from Apex:

☐ Mobile Device***:** (_____)_____

☐ Text Message***:** (_____)_____

☐ E-Mail**:** _____

☐ By checking this box, you agree to receive SMS messages from ApexNetwork Physical Therapy.

*******Standard message rates, data rates, and/or restrictions may apply, and by consenting to receive notifications from Apex you agree to be solely responsible for all message fees and/or data fees that you incur from receiving notifications from Apex.*

I have had the opportunity to review, read, and request a copy of the ApexNetwork Physical Therapy HIPAA Notice of Privacy Practices.

Patient/Guardian Printed Name: _____

Patient/Guardian Signature: _____ Date: _____