

Mission Peak Physical Therapy Intake Forms

# Profile Information — Step 1 of 3

Please take a moment to fill out our online intake form before your visit.

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Prefix / Title: \_\_\_\_\_

Email: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Primary Care Physician Phone (if known): \_\_\_\_\_

Name of Referring Professional (if applicable): \_\_\_\_\_

Referring professional phone (if known): \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How did you hear about us? (ie. Doctor, friend, online directory drove-by, returning patient):

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## Questionnaires — Step 2 of 3

**Physical Therapy Intake Form:** *This form contains a series of questions designed to help your physical therapist understand how you feel, and determine how well you are able to do your usual activities. This information will help your therapist give you the best possible care. Please answer every question as accurately and completely as you can. If your medical information changes during the course of your physical therapy care, it is your responsibility to notify your physical therapist of these changes.*

What are your goals for Physical Therapy? \_\_\_\_\_

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What are your symptoms? \_\_\_\_\_

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Describe the nature of your symptoms (check all that apply):

sharp    dull    aching

burning    tingling    numbness

throbbing    constant    intermittent

Please rate your pain on a scale of 0 to 10: \_\_\_\_\_

Date of onset of symptoms: \_\_\_\_\_

How did your injury occur/symptoms begin? (ie. a fall, sports injury, work injury, motor vehicle accident) \_\_\_\_\_

Since onset, are your symptoms getting (check one):

- better  worse  no change

Are your symptoms most aggravated (check one):

- In the morning  In the afternoon  In the evening  No change related to time of day

Does your pain wake you up at night?

- Yes  No

What aggravates your symptoms? (check all that apply)

- sitting  standing  lying down  going from sitting to/from standing  walking
- running  work/household activities  bending  pushing/pulling  lifting
- reaching overhead  reaching behind body  reaching across body  squatting
- kneeling  repetitive activities  sports/recreational activities
- eating/chewing/swallowing  stress  coughing/sneezing  taking a deep breath

What relieves your symptoms? (check all that apply):

- rest  ice  heat  massage
- bracing or taping  exercise  stretching  sitting
- standing  lying down  changing positions  medication

Have you experienced these symptoms in the past?:

- Yes. (If so, when?) \_\_\_\_\_

- No

Ongoing

Have you had any of the following tests for your symptoms? (If yes, what were the results?)

X-Ray: \_\_\_\_\_

MRI: \_\_\_\_\_

CT Scan: \_\_\_\_\_

Arthrogram: \_\_\_\_\_

Ultrasound: \_\_\_\_\_

Other: \_\_\_\_\_

Medical History: Cardiovascular (check all that apply):

high blood pressure

low blood pressure

congestive heart failure

heart attack

stroke/CVA

pacemaker or similar device

heart disease

Medical History: Pulmonary (check all that apply):

chronic cough

shortness of breath

bronchitis

asthma

COPD

Medical History: Head/Neck Region (check all that apply):

history of headaches

history of migraines

vision problems

vision loss

ear problems

hearing loss

dizziness/vertigo

fainting/drop attacks

difficulty chewing or swallowing

Medical History: Other Conditions (check all that apply):

cancer (specify type and current status): \_\_\_\_\_

diabetes

bone/joint disorders

- osteoporosis
- epilepsy/seizure disorders
- anxiety
- depression

Medical History: Women's Health (check all that apply):

- currently pregnant (please specify due date): \_\_\_\_\_
- If applicable, are currently being monitored for any complications during your pregnancy

Medical History: Other Medical Symptoms (check all that apply):

- difficulty with bowel or bladder function
- fever/chills
- genital/anal area numbness
- numbness in both arms and legs
- generalized weakness
- unexplained weight change
- night pain

Please list your current medications and the conditions it treats: \_\_\_\_\_

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Please list any known allergies: \_\_\_\_\_

Surgical History (list type of surgery and date or surgery): \_\_\_\_\_

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Do you exercise? (If yes, how often and what types of exercise?)

Yes \_\_\_\_\_

No

Are you currently working? (If yes, part-time/full time? If no, is your injury preventing you from working?)

Yes: \_\_\_\_\_

No: \_\_\_\_\_

## Consents — Step 3 of 3

Email Communication

### Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

I would like email notifications of new, cancelled, and rescheduled appointments

Email 2 days before appointment  Text Message (SMS) 24 hours before appointment

### News and Special Promotions

Yes, I would like to receive news and special promotions from Mission Peak Physical Therapy by email

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# Physical Therapy Intake form — Consents

## Accuracy of Information

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information or omitting information can be dangerous to my health. It is my responsibility to inform my physical therapist of any changes in my medical condition.

- \* I certify that the above medical information is correct to my knowledge.

## Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my primary care physician and/or referring provider, including the staff members of those providers, as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties other than my primary care provider and/or referring provider and their staff members with my permission. When applicable, I authorize the clinic, its associated health professionals, and/or my insurance company to release any information required for the purpose of evaluating and administering claims of insurance benefits and the payment of said benefits for all services rendered to me by Mission Peak Physical Therapy PLLC.

- \* I have been received notice, read, and understand my privacy rights and practices.

## Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapist's day that could have been filled by another patient. As such, we require 24 hours' notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours' notice, or miss their appointment, will be charged a \$50 cancellation fee. Patients who need to cancel due to personal and family emergency or sudden illness will not be charged a fee; if an emergency or sudden illness occurs, please notify the clinic as soon as possible.

- \* I am aware of the Cancellation Policy.

## Consent to Treatment

I grant permission for licensed physical therapists at Mission Peak Physical Therapy PLLC to perform such examinations and therapeutic treatments and/or procedures as may be professionally deemed necessary for appropriate evaluation and treatment of my condition.

For Minors: I (patient or legal guardian for patient who is a minor) grant permission for licensed physical therapists at Mission Peak Physical Therapy PLLC to perform such examinations and therapeutic treatments and/or procedures as may be professionally deemed necessary for appropriate evaluation and treatment of the condition of my child.



\* I consent to treatment as described above.

## Financial Agreement

**In-Network Physical Therapy Services:** I understand that if Mission Peak Physical Therapy PLLC is an in-network provider with my insurance company, I authorize direct payment of my insurance benefits to be paid directly to Mission Peak Physical Therapy PLLC for all services rendered to me by Mission Peak Physical Therapy PLLC. Additionally, I understand that I am financially responsible for all co-payments, deductibles, share of costs, patient responsibilities and non-covered services as determined by my insurance plan at the time of claims processing

**Out-of-Network Physical Therapy Services:** I understand that as an out-of-network provider, Mission Peak Physical Therapy PLLC will require full payment at the time of service. If I would like assistance in seeking reimbursement for physical therapy services, I will request in writing for Mission Peak Physical Therapy PLLC to provide me with a superbill that I will submit to my insurance company. Mission Peak Physical Therapy PLLC will assist me in determining my out-of-network benefits but it is ultimately my responsibility to confirm what my out-of-network benefits are. I understand and agree that the entire cost of treatment provided by Mission Peak Physical Therapy PLLC is my responsibility, regardless of whether any out-of-network benefits cover part of all of said cost.

\* I agree.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

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

Parent/Guardian Signature: \_\_\_\_\_

Printed Name of Parent/Guardian: \_\_\_\_\_

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