# 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):

____________________________________________________

# 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? ________________________________________________

__________________________________________________________________________________

What are your symptoms? ______________________________________________________________

__________________________________________________________________________________

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. Childbirth, sports injury, pregnancy, lifting injury)___________________________________________________________________

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 ☐ squatting ☐ kneeling ☐ repetitive activities

☐ sports/recreational activities ☐ stress ☐ coughing/sneezing

☐ menstruation ☐ sexual activity ☐ 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: (check all that apply and state specific condition when applicable):

☐ Cardiovascular: ____________________________________________________

☐ Pulmonary/lungs: __________________________________________________

☐ Cancer (state specific type and current status): ___________________________

☐ Diabetes: _________________________________________________________

☐ Bone/Joint Disorders: _______________________________________________

☐ pacemaker or similar implanted device: ___________________________________

☐ Osteoporosis: _____________________________________________________

☐ Epilepsy/Seizure Disorders: ___________________________________________

☐ Anxiety: _________________________________________________________

☐ Depression: _______________________________________________________________

☐ History of headaches/Migraines: ______________________________________________

☐ Vision problems: ___________________________________________________________

☐ Hearing loss: ______________________________________________________________

☐ Dizziness/vertigo: __________________________________________________________

☐ Other: ____________________________________________________________________

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?

_________________________________________________________________________________

☐ Sexually Active (check box if yes)

☐ If applicable, please state any pain or problems with sexual activity: ___________________________

☐ Date of last Pelvic Exam and any pertinent findings: _________________________________________

☐ Date of last Urinalysis and any pertinent findings: ___________________________________________

☐ History of sexually transmitted diseases: __________________________________________________

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: ___________________________

_________________________________________________________________________________

_________________________________________________________________________________

Please list any known allergies: _________________________________________________________

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

_________________________________________________________________________________

_________________________________________________________________________________

Bowel and Bladder Symptoms (check any that apply):

☐ difficulty initiating stream or bowel movement ☐ no perception of bladder fullness ☐ weak, slow, or intermittent stream ☐ frequent toileting to avoid problems ☐ dribbling after stream ends ☐ pain/burning during urination or defecation ☐ blood in urine or stool

Frequency of urinary leakage (in 24 hour period): ______________________________________

Amount of urinary leakage:

☐ none ☐ few drops ☐ wet underwear ☐ other

Activities or positions associated with leakage:

☐ no leakage ☐ sitting ☐ standing ☐ lying down ☐ changing positions
☐ coughing ☐ laughing ☐ sneezing ☐ running ☐ walking
☐ on way to toilet ☐ when constipated ☐ sexual activity ☐ strong urge ☐ other

Length of time you are able to delay emptying: ________________________________________

Frequency of urination: ________________________________________

How many bowel movements per week? ____________________________

Fluid intake (8 oz glasses) per day? ________________________________

Prolapse or "falling out" symptoms

☐ never ☐ during menstruation ☐ pressure at end of day ☐ pressure with straining ☐ pressure with standing ☐ pressure all day ☐ other

Birth experience information (if applicable):

☐ how many children do you have? _______________________________

☐ how old are they now? _______________________________________

☐ type of birth for each (vaginal or c-section) ____________________________

☐ how long was the pushing phase? __________________________________

☐ if c-section, was it planned or emergency? _______________________________

☐ did you have an episiotomy or tear? _______________________________________

☐ did you have any other complications associated with childbirth? ______________________

______________________________________________________________________________

Postpartum health check (check any that apply):

☐ diastasis (abdominal separation) ☐ non-resolving hemorrhoids ☐ constipation or straining

☐ urinary incontinence ☐ urinary urgency ☐ back pain and/or pelvic girdle pain

☐ pain in other joints ☐ clicking or pain at the pubic symphysis or sacroiliac iliac joints (front and back of pelvis) ☐ difficulty breathing/shortness of breath ☐ painful intercourse ☐ depression

Are you currently receiving treatment from another health care professional? _________________

_________________________________________________________________________________

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

---

# 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: ___________________________