

FACILITY PATIENT INTAKE AND CONSENT FORM

Internal Use Only:

Account #

Account Type

Office #

First Name _____ MI _____ Date of Injury/Onset _____ Today's Date _____
 Last Name _____ Date of Birth _____ Age _____
 Address _____ Sex: M F Marital Status: S M D W
 _____ Home Phone _____
 City _____ State _____ Zip _____ Work Phone _____

Responsible Party _____
 Address _____
 City _____ State _____ Zip _____
 Phone Number _____
 Relationship to Responsible Party _____

Cell Phone _____
 Injury Area _____
 Accident Related: Yes No
 If Accident: Auto Work Other
 Nature of Accident _____
 SS# _____

Employer _____
 Address _____
 City _____ State _____ Zip _____

Occupation _____
 Contact at Employer _____

Referring Physician _____ Phone Number _____

Primary Insurance _____ Insured Name _____
 Group # _____ ID # _____ Address _____ City _____
 Insured Employer _____ State _____ Zip _____ Phone _____
 Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: M F

Second Insurance _____ Insured Name _____
 Group # _____ ID # _____ Address _____ City _____
 Insured Employer _____ State _____ Zip _____ Phone _____
 Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: M F

Emergency Contact _____ Daytime Phone Number _____

Are you receiving or have you recently received home health services? Yes No
 Are you receiving or have you recently received other therapy services? Yes No Please initial: _____

CONSENT TO TREATMENT: I consent to rehabilitation and related services at FACILITY. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____

TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

LIABILITY: I know and agree that FACILITY is not responsible for loss or damage to personal valuables. _____

WAIVER AND RELEASE: I hereby release, discharge and acquit FACILITY, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. _____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to FACILITY and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. _____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Witness Signature _____

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of Clair PT. This form must be completed in its entirety and must be provided to Clinic Name prior to initiation of therapy services.

CLAIR PHYSICAL THERAPY MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____
REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____
CAUSE OF INJURY OR ONSET: _____ ARE YOU PRESENTLY WORKING? Y N
PRIMARY CARE PHYSICIAN'S NAME: _____ DATE OF NEXT MD APPT: _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR
DO YOU USE TOBACCO? (circle one) YES NO IF YES, HOW MUCH? _____

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN _____ AND WHY _____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE / WHAT WERE THE RESULTS: _____

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: _____

ALLERGIES: Medication _____ Reaction _____ Medication _____ Reaction _____

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction _____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction _____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> ASTHMA <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> ASTHMA <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> COPD <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> FRACTURES | <input type="checkbox"/> Other |
| <input type="checkbox"/> CARDIO/VASCULAR PROBLEMS | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SEIZURES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> HALTER MONITOR - currently wearing? | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> HEPATITIS / HIV | |
| <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> KIDNEY PROBLEMS | |
| <input type="checkbox"/> LOW BLOOD PRESSURE | | |
| <input type="checkbox"/> CURRENTLY PREGNANT | | |

If checked any above, explain: _____

ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____ Date _____