Carolina Rehabilitation/Brunswick Physical Therapy Associates/Edwards and Associates Physical Therapy Intake Form

First Name_____ **MI**_____ **Last Name**_____ **Nick Name**_____
Birthdate: _____/_____/_____ **SS #** _____-_____-_____ **Sex: Male / Female**

Mailing Address_____ **City**_____ **St**_____ **Zip**_____

Home Phone(_____**)** _____-_____ **Cell Phone(**_____**)** _____-_____ **Work(**_____**)** _____-_____
Would you like to receive reminders of appointments by: Text Message: Yes / No **Email:** Yes / No

Email Address:_____ **Employer:**_____ **Phone(**_____**)** _____-_____

Emergency Contact:_____ **Relationship:**_____ **Phone(**_____**)** _____-_____
Responsible Party/Guardian(if you are not the primary account holder) **Name:**_____

Relationship:_____ **Phone:(**_____**)** _____-_____ **SS #** _____-_____-_____

Referring MD:_____ **Next Visit**___/___/___ **Primary MD:**_____ **Next Visit** ___/___/____

Have you had ANY Physical or Speech Therapy during this calendar year? Yes / No
Are you currently or have you in the past 90 days received ANY home health nursing, therapy? Yes / No
Do you have an attorney? Yes / No **Name of Firm**_____ **Phone Number**_____

If you have an insurance card please give it to the receptionist to copy (even if this is workers comp) your co-pay or coinsurance is due at each date of service. Please call to cancel any appointments you cannot keep. If you do not call before your appointment you may be charged with an office visit of $35. Returned check fee is $35.00. These fees will not be covered by insurance.

Workers Comp or Auto Insurance

Workers Comp Yes / No **Auto Accident** Yes / No **Date Injured:**____/____/____
Case Manager:_____ **Phone Number(**_____**)** _____-_____
Carolina Rehabilitation Inc. will bill Workers Compensation claims with the proper insurance company. Caseworkers will be kept up to date on progress, and any missed appointments. If Workers Compensation denies my claim, Carolina Rehabilitation Inc. will file with my insurance company. I will be responsible for payments not covered or approved by workers compensation.
In the case of legal settlements pending or otherwise, regarding this injury. I agree to make full payment for this debt regardless of the settlement decision. I understand if a legal settlement can not be reached I will be required to make payments of this debt, in an amount and time schedule to be set by Carolina Rehabilitation Inc.

Signature:_____ **Date:**_____/_____/_____

Medicare Patients Only

Medicare Patients Statement to permit payment to the provider for therapy services. I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. This authorization shall apply to the period covering these services.

Signature:_____ **Date:**_____/_____/____

Patient Responsibility and Consent to Treat

I understand that any balance remaining on my account for longer than 60 days may have a late charge of 1 ½ % per month (18% apr) added. I authorize payment of insurance benefits covering these services directly to Carolina Rehabilitation, Inc. I also hereby acknowledge my responsibility for full payment of this debt and waive my rights of defense under the statute of limitations. I also understand that it is my responsibility to obtain any referrals, pre-authorization, benefits and network provider information.

I acknowledge receipt of this notice of the privacy practices of Carolina Rehabilitation, Inc.

By signing this, I accept responsibility of charges and I consent to Physical Therapy Treatment as directed including modalities.

Signature:_____ **Date:**_____/_____/____

Carolina Rehabilitation

Information Release Form

Patient Name:_____

Birthdate: ____/____/_____

I _____, give my permission to Carolina Rehabilitation to:

CIRCLE ONE

Leave a message on my phone **Yes / No**

Discuss my Physical Therapy with others **Yes / No**

If yes, whom: _____ Relationship:_____ Phone(_____) _____-_____

_____ Relationship:_____ Phone(_____) _____-_____

_____ Relationship:_____ Phone(_____) _____-_____

Release Physical Therapy Reports to Physicians other than referring:

Physician Name:_____ Phone(_____) _____-_____ Fax (_____) _____-_____

Physician Name:_____ Phone(_____) _____-_____ Fax (_____) _____-_____

Signature of Patient or Responsible Party: _____ Date:_____

Print Name and Relationship:_____

Staff Witness Signature:_____ Date:_____

Patient Name:_____ **Date:**_____

Date Injured/Date of Surgery:_____

Height_____ **Weight**_____

Describe your symptoms: _____

Circle One: Sharp Dull Ache Numbness/Tingling Shooting Burning

When did your symptoms start?_____

How did your symptoms start?_____

What makes your symptoms worse?_____

What makes your symptoms better?_____

With which activities are you having trouble(check all that apply)

___Walking ___Difficulty driving ___Getting in/out of bed

___Stairs ___Diffuculty caring for others ___Getting in/out of the car

___Rising from chair/toilet ___Diffuculty with chores/housework ___Prolonged sitting

___Difficulty dressing/bathing ___Difficulty with work ___Prolonged standing

Please fill in all that apply:

Allergies	O Yes O No	Dizzy Spells	O Yes O No	MRSA	O Yes O No
Anemia	O Yes O No	Emphysema/Bronchitis	O Yes O No	Multiple Sclerosis	O Yes O No
Anxiety	O Yes O No	Fibromyalgia	O Yes O No	Muscular Disease	O Yes O No
Arthritis	O Yes O No	Fracture	O Yes O No	Osteoporosis	O Yes O No
Asthma	O Yes O No	Gallbladder Problems	O Yes O No	Parkinsons	O Yes O No
Autoimmune Disorder	O Yes O No	Headaches	O Yes O No	Rheumatoid Arthritis	O Yes O No
Cancer	O Yes O No	Hearing Impairment	O Yes O No	Seizures	O Yes O No
Cardiac Conditions	O Yes O No	Hepatitis	O Yes O No	Smoking	O Yes O No
Cardiac Pacemaker	O Yes O No	High/Low Blood Pressure	O Yes O No	Speech Problems	O Yes O No
Chemical Dependency	O Yes O No	High Cholesterol	O Yes O No	Strokes	O Yes O No
Circulation Problems	O Yes O No	HIV/AIDS	O Yes O No	Thyroid Disease	O Yes O No
Currently Pregnant	O Yes O No	Incontinence	O Yes O No	Tuberculosis	O Yes O No
Depression	O Yes O No	Kidney Problems	O Yes O No	Vision Problems	O Yes O No
Diabetes	O Yes O No	Metal Implants	O Yes O No		

Have you ever had surgery? ___ Yes ___ No

If yes, please list the date and type of surgery:

_____

Medications:

_____

In General, would you say your overall health right now is…

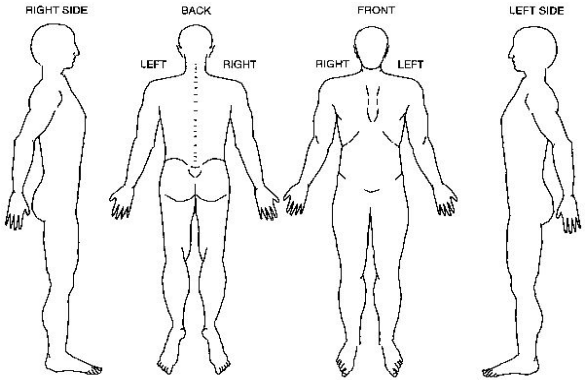
___ Excellent ___Very Good ___Good ___Fair ___Poor

What are your goals with Physical Therapy?_____

Rate your current pain on a scale of 0 to 10 where 0 is no pain and 10 is the worst imaginable

1 2 3 4 5 6 7 8 9 10

Please mark on the drawings where you feel your pain



Patient Name:_____ **Date:**_____

Birthdate:___/___/____

Medications

Please list prescriptions or over the counter medications or provide a list to copy

Medication	Dosage

Continue on back if needed

****Please inform your therapist anytime you have had a change to your medications****