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 cannot 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? _____

To help us understand your symptoms, please circle all that apply.

My pain is worse: in the morning / during the day / at night / constant / with activity / during rest

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

___Walking	___Difficulty driving	___Getting in/out of bed
___Stairs	___Difficulty caring for others	___Getting in/out of the car
___Rising from chair/toilet	___Difficulty with chores/housework	___Prolonged sitting
___Difficulty dressing/bathing	___Difficulty with work	___Prolonged standing

Have you had any falls in the past 6 months? □ Yes □ No
If yes, how many times? _____
If yes, please describe the nature of the fall/falls: _____
If yes, please describe if an injury/injuries occurred: _____
_____

Have you had a decrease in your activity level because of a fear of falling? □ Yes □ No

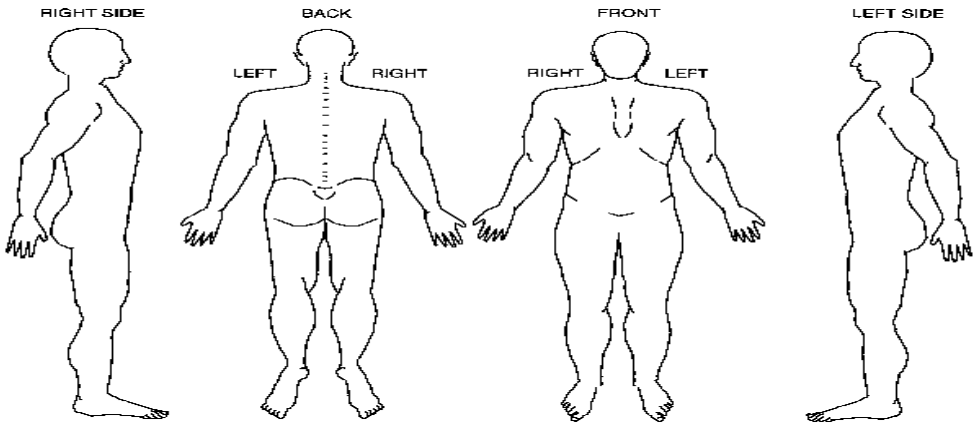
Are you reluctant to leave your home because of a fear of falling? □ Yes □ No

What are your goals with Physical Therapy?_____

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best _____ and at its worst_____ Current pain level_____

Please mark on the drawings where you feel your pain



Patient Name: _____ Date:_____

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

____Excellent ____Very Good ____Good ____Fair ____Poor

Have you ever had surgery? ___ Yes ___ No

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

_____

_____

Please fill in all that apply: If yes, indicate date of onset.

		Date			Date			Date
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 Cholesterol	O Yes O No		Speech Problems	O Yes O No	
Chemical Dependency	O Yes O No		High/Low Blood Pressure	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	
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				

Is there any other information regarding your past medical history that we should know about?

_____

_____

What kinds of tests have been done for your current problem? (Check if applicable)
____ MRI ____ X-Ray ____CT Scan _____Myelogram

Please list place of service where you had your test performed.

_____

Patient Name:_____ Date:_____

Birthdate:___/___/____

Medications

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

Medication	Dosage	Frequency	Route of Administration

Continue on back if needed

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

Edwards and Associates Physical Therapy

Payment of Services

Patient Name:_____ Date of Birth:_____

Carolina Rehabilitation Inc./ Edwards and Associates Physical Therapy is concerned first with the health and rehabilitation of the patients under our care. We understand that payment for services can be difficult under some circumstances. In order to provide services we ask you to read and sign this document.

I hereby acknowledge my responsibility for full payment of this debt and waive my rights of defense under the statute of limitations. I also understand it is my responsibility to obtain any referrals, pre-authorization, benefits and network provider information, and provide them to Carolina Rehabilitation Inc./Edwards and Assoc Physical Therapy. I authorize payment of insurance benefits and or settlements covering these services directly to Carolina Rehabilitation Inc. / Edwards and Assoc Physical Therapy.

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Signature _____

Date _____