

Patient Intake Form

Amy Hill Physical Therapy & Pilates P.C. (720-302-5022)

Patient Information

Name: _____ MI: ____ DOB: _____ Age: _____ Gender: ____

Preferred Email: _____ Social Security Number: _____

Preferred Phone: _____ Secondary Phone (if applicable): _____

Address: _____ City: _____ State: ____ Zip: _____

Home Status/Functional Level:

Lives With: Alone / Spouse/Partner / Family / Friends / Other

Home: 1 story / 2 Story / Apartment / Mobile Home / Other

How many sets of stairs do you have? _____ Are there handrails: Yes No

Do you?: Smoke? How much ____ / Drink Alcohol? How much ____

Emergency Contact: _____ Relation to Patient: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone Number: _____ Secondary Method of Contact _____

Employer Name: _____ Employer Phone: _____

This Section is for Medical Record Compliance - if you want to opt out check here

Primary Language: English / Spanish / ASL / French / Japanese / Dutch

Race: Native American or Alaskan Native / Asian / Black / Native Hawaiian or Other Pacific Islander / White

Ethnicity: Hispanic or Latino / Not Hispanic or Latino

Insurance Information

Primary Insurance:

Insurance Company: _____ Plan Name: _____

Subscriber ID: _____ Group Number: _____ Visit Co-Pay: _____

Primary Insured(PolicyHolder): _____ Primary DOB: _____

Primary SSN: _____ Patient Relationship to Primary: _____

Secondary Insurance:

Insurance Company: _____ Plan Name: _____

Subscriber ID: _____ Group Number: _____ Visit Co-Pay: _____

Primary Insured(PolicyHolder): _____ Primary DOB: _____

Primary SSN: _____ Patient Relationship to Primary: _____

Financially Responsible: (Only if the person responsible for the bill is not the patient)

Name: _____ DOB: _____ SSN: _____

Relationship to patient: _____

Signature: _____ Today's Date: _____

Injury Information

Background

Date of injury: _____ Affected Area: _____ Referred by: _____

Why are you seeking therapy? _____

How did your injury start?: _____

What makes symptoms worse?: _____

Have you had previous therapy for this injury?: Yes No

If yes, how many visits? _____ When was your last visit? _____

What kinds of treatment have you received for this injury?

<input type="radio"/> None	<input type="radio"/> Massage	<input type="radio"/> TENS Unit	<input type="radio"/> Bracing
<input type="radio"/> Medication	<input type="radio"/> Exercise	<input type="radio"/> Traction	<input type="radio"/> Pain Clinic
<input type="radio"/> PT/OT	<input type="radio"/> Injections	<input type="radio"/> Surgery	<input type="radio"/> Other _____
<input type="radio"/> Chiropractic	<input type="radio"/> Acupuncture	<input type="radio"/> Splinting/Taping	

List any surgeries associated with the condition?: _____

Do you have any assistive equipment? Check all which apply: Crutches / Walker /

Grab bars / Cane / Wheelchair / Tub Bench / Lift Chair / Others

Have you had any of the following for this condition? What were the results?

<input type="radio"/> None	<input type="radio"/> CT Scan _____	<input type="radio"/> EMG _____
<input type="radio"/> X-Ray _____	<input type="radio"/> Bone Scan _____	<input type="radio"/> Diagnostic Arthroscopy
<input type="radio"/> MRI _____	<input type="radio"/> Arthrogram _____	<input type="radio"/> Doppler/Ultrasound

Are you on medication for this injury?: _____

Prescribed or Over the Counter?

How many falls last month? _____ Last year? _____

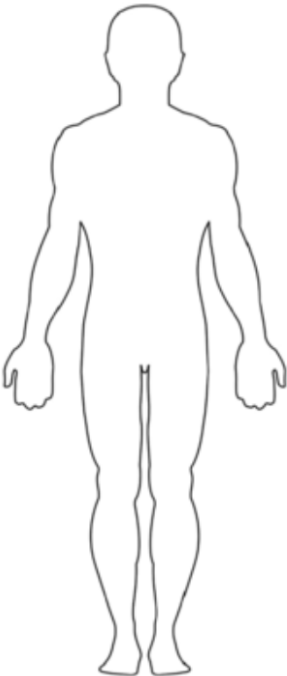
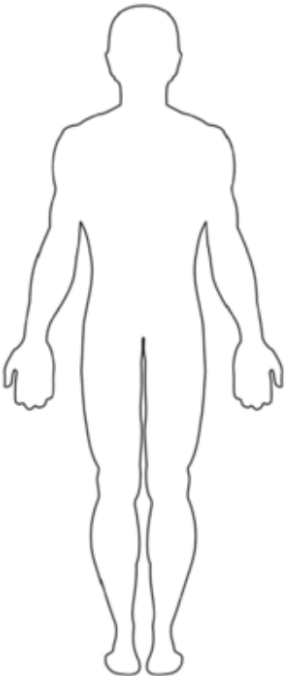
Is there an attorney involved?: Yes No

Are you currently receiving home health services?: Yes No

Has your injury hindered you from working? Yes No

Pain Questionnaire

To the best of your ability, please fill this out regarding your pain

<p>*Please indicate the location of your pain</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>Front</p>  </div> <div style="text-align: center;"> <p>Back</p>  </div> </div>	<p>Please rate your pain on a scale of 0 to 10: 0 - no pain 10 - excruciating pain</p> <p>_____ Worst it has been</p> <p>_____ At this moment</p> <p>_____ Best</p> <p>_____ Activity</p> <p>Are your symptoms worse in</p> <p><input type="radio"/> Morning</p> <p><input type="radio"/> Afternoon</p> <p><input type="radio"/> Evening</p> <p><input type="radio"/> Inconsistent</p> <p>Which side? <input type="radio"/> Left / <input type="radio"/> Right</p> <p>Which of the following causes pain</p> <p><input type="radio"/> Sitting</p> <p><input type="radio"/> Standing</p> <p><input type="radio"/> Walking</p> <p><input type="radio"/> Stairs - up</p> <p><input type="radio"/> Stairs - down</p> <p><input type="radio"/> Sit to stand</p> <p><input type="radio"/> Bending</p> <p><input type="radio"/> Voiding</p> <p><input type="radio"/> Lying Down</p> <p><input type="radio"/> Cough</p>												
<p>Describe your pain? (select more than 1)</p> <table border="1"> <tr> <td><input type="radio"/> Tingling</td> <td><input type="radio"/> Piercing</td> <td><input type="radio"/> Aching</td> </tr> <tr> <td><input type="radio"/> Dull</td> <td><input type="radio"/> Numbness</td> <td><input type="radio"/> Burning</td> </tr> <tr> <td><input type="radio"/> Superficial</td> <td><input type="radio"/> Sharpness</td> <td><input type="radio"/> Deep</td> </tr> <tr> <td><input type="radio"/> Sharp</td> <td><input type="radio"/> Intermittent</td> <td><input type="radio"/> Stabbing</td> </tr> </table>	<input type="radio"/> Tingling	<input type="radio"/> Piercing	<input type="radio"/> Aching	<input type="radio"/> Dull	<input type="radio"/> Numbness	<input type="radio"/> Burning	<input type="radio"/> Superficial	<input type="radio"/> Sharpness	<input type="radio"/> Deep	<input type="radio"/> Sharp	<input type="radio"/> Intermittent	<input type="radio"/> Stabbing	
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Which of the following are some of your goals for physical therapy?

<p><input type="radio"/> Decrease Pain</p> <p><input type="radio"/> Less Difficulty with Work Activities</p> <p><input type="radio"/> Sleep Longer Than _____ Hours</p> <p><input type="radio"/> Improve Movement</p> <p><input type="radio"/> Return to Recreational Activities/Sports</p>	<p><input type="radio"/> Improve Health</p> <p><input type="radio"/> Stand Longer Than _____ Minutes/Hours</p> <p><input type="radio"/> Sit Longer Than _____ Minutes/Hours</p> <p><input type="radio"/> Less Difficulty with Home Activities</p> <p><input type="radio"/> Ability to use Stairs</p>
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Any additional goals for PT? _____

Health History

Current Medications

None / Prescription / Over the Counter / Herbals / Vitamins / Other

Medical History

<input type="radio"/> No Known PMH <input type="radio"/> Alzheimer's <input type="radio"/> Cardiovascular Disease <input type="radio"/> Cauda Equina Syndrome <input type="radio"/> Cerebral Vascular Accident <input type="radio"/> Current Infection <input type="radio"/> Diabetes Mellitus Type 1	<input type="radio"/> Diabetes Mellitus Type 2 <input type="radio"/> Fibromyalgia <input type="radio"/> Fracture <input type="radio"/> High Blood Pressure <input type="radio"/> History of Cancer <input type="radio"/> Huntington's <input type="radio"/> Immunosuppression <input type="radio"/> Lupus	<input type="radio"/> Muscular Dystrophy <input type="radio"/> Obesity <input type="radio"/> Osteoarthritis <input type="radio"/> Parkinson's <input type="radio"/> Rheumatoid Arthritis <input type="radio"/> Traumatic Brain Injury <input type="radio"/> Other _____
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Authorization

Notice of Privacy Practices

I certify that I am the patient or legal guardian that has been listed. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to AHPT. I authorize this office and its staff to examine/treat my condition as the seen fit. I hereby authorize the office to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between the insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Privacy Practices

I acknowledge that I was provided with a copy of the *Notice of Privacy Practices* and that I have read or had an opportunity to read and understand the notice.

I agree to the statement of authorization

Final Signatures

Name of the Insured (Printed) _____

Patient Signature _____

Guardian Signature _____