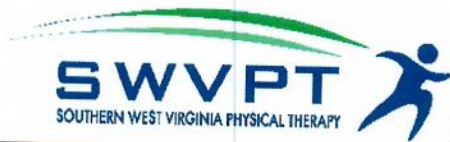


Initial Patient Intake Form

Patient

Name:		Date of Birth:	Gender: M □ F
Billing Address:		City:	State: / Zip:
Phone (H):	Phone (C):		Phone (W):
Email:		Social Security Number (Required):	

How did you hear about us? Please allow us to thank someone for your referral.
□ Physician (Name) ______________________ □ Online □ Other ____________________
□ Patient (Name) ______________________

Insurance

Primary Insurance:	Secondary Insurance:
Patient Relationship to Insured: □ Self □ Spouse □ Child	
Insured name (if not self):	
Insured Birth date (if not self):	
Is treatment related to: □ Motor Vehicle Accident ? If yes, STOP NOW AND NOTIFY FRONT OFFICE STAFF.	
Is treatment related to: □ Work Injury ? If yes, date of work injury:	
Claim Number (if applicable):	
Employer Name, Address, & Phone:	

Contact

We are unable to share medical information with any person other than the patient. Please list any person(s) with whom we are authorized to discuss your medical condition, appointments, and billing information with.

Name:	Relationship to Patient:
Phone (C):	Phone (H):

Acknowledgement and Authorization

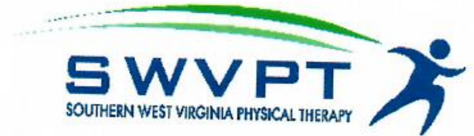
- ✓ I have read, understand, and agree to be bound by the SWVPT Financial Policy. I also understand and agree that such terms may be amended by the practice.
- ✓ I have read, understand, and agree with the SWVPT Attendance Policy.
- ✓ I have read, understand, and agree to the SWVPT Release of Information statement.
- ✓ I have read, understand, and agree to the SWVPT Consent statement.

I have read the Consent for Treatment, Payment, and Healthcare Operations form and agree to the statements above.

____
Patient Signature or Guardian/Responsible Party

____
Date

Please take time to fill this form out to the best of your ability. It will help your Physical Therapist choose the most effective treatment for your injury/pain.



Medical History Form

1Step

Name:	Age:	Height:	Weight:
Occupation:	Full-Time ☐ Part-Time ☐ Light Duty		
Referring Physician:	Follow-Up Appointment Date:		
What are we examining/treating today?			

2Step

Did you have an injury? ☐ Yes ☐ No	If yes, on what date?	If yes, describe:
If no, approximately when did your pain/symptoms begin?		
Have you had surgery for this problem? ☐ Yes ☐ No	If yes, on what date?	
Have you had this problem in the past? ☐ Yes ☐ No		
Have you recently had any of the following: ☐ X-ray ☐ MRI ☐ CT Scan ☐ Bone Density Scan ☐ Nerve Test PHYSICAL THERAPY OR CHIROPRACTIC VISITS IN THE LAST YEAR ☐		
Did you receive any injections for your current problem? ☐ Yes ☐ No		

Please rate your pain below. 0 = no pain, 10 = severe pain (emergency room)

Worst rating since pain began	1	2	3	4	5	6	7	8	9	10
Current rating	1	2	3	4	5	6	7	8	9	10
Best rating since pain began	1	2	3	4	5	6	7	8	9	10

On the body diagram to the right, place the correct symbol on the diagram that best describes your pain/symptoms.

Key
Sharp: ☐
Dull/achy: =
Throbbing: O
Burning: Δ
Numbness: +
Tingling: •
Radiating: use arrows

3Step

Please mark if you currently have or have ever had any of the following:

☐ High Blood Pressure	☐ Cancer	☐ Incontinence	☐ Chest Pain
☐ High Cholesterol	☐ Asthma/COPD	☐ Fractures	☐ Kidney Disease
☐ Diabetes	☐ Hypothyroidism	☐ Poor circulation	☐ Multiple Sclerosis
☐ Heart Attack	☐ Hyperthyroidism	☐ Seizures	☐ Huntington's Disease
☐ Stroke	☐ Anxiety	☐ Hernia	☐ Fibromyalgia
☐ Arthritis	☐ Depression	☐ Dizziness	☐ Ehlers-Danlos
☐ Osteoporosis	☐ Bipolar Disorder	☐ Headaches	☐ Other: ________________

SWVPT
SOUTHERN WEST VIRGINIA PHYSICAL THERAPY

Step 4

List all of your previous surgeries using the numbers below (provide the year of each procedure if possible):	
1.	4.
2.	5.
3.	6.
Do you currently have a pacemaker or defibrillator? □ Yes □ No	
Have you experienced any unexplained weight-loss? □ Yes □ No	
Have you had any falls in the past year? □ Yes □ No	If yes, were you injured? □ Yes □ No
Do you experience numbness or tingling? □ Yes □ No	If yes, explain:
What is your main goal for physical therapy?	

Step 5

Use the table below to provide us with your medications. **If you brought a medication list, skip step 5 and let our secretary scan your list into our system.**

Medication Name	Reason for Taking (e.g. pain, anxiety)	Dosage (e.g. one tablet)	Frequency (e.g. two times per day)	Route (e.g. by mouth, injection)

Consent for Treatment, Payment and Healthcare Operations

Patient Name: ______________________________ **Please initial each line below:**

____ **Consent**: I consent to and authorize SWVPT to administer physical therapy treatment under the direction and supervision of a physical therapist. I understand that, as in all practices of medicine, physical therapy may have risks. I understand that I have the right to ask questions regarding risks and my condition and have them answered prior to treatment. It is up to me, the patient, to inform the therapist and/or support staff about any other health conditions I may have.

____ **No Guarantee**: I understand that no guarantees have been made to me as a result of treatment or examination of myself by the physical therapist and/or support staff. I understand that the practice of physical therapy is not an exact science and treatment and results may vary from patient to patient.

____ **Minors**: The parent or guardian accompanying a minor is responsible for payment of services. Unaccompanied minors will be denied treatment until all necessary forms have been signed by the parent or guardian.

____ **Release of Information**: SWVPT releases patient health care information for the purpose of treatment or payment to other health care organizations as well as the patient's insurance company as explained in our HIPAA Notice of Privacy Practices. I understand that I have the right to review these practices at any time and hereby authorize the release of any medical and/or demographic information pertinent to my case to any insurance company, adjustor, attorney or healthcare facility for the purpose of treatment, processing claims and securing payment.

____ **Attendance Policy**: A 24-hour cancellation notice is required if you are unable to attend an appointment. Failure to notify us within 24 hours may result in a cancellation fee on your account. If no call is received before a missed appointment a NO SHOW will be marked in your chart. After 3 NO SHOW appointments, you may be discharged from physical therapy resulting in a letter to your referring physician explaining discharge due to non-compliance. **If you are a worker's compensation patient, a representative from your compensation company will call our office to verify attendance history.

____ **Financial Policy**: Please understand that payment of your bill is considered a part of your treatment. We accept most insurances, cash, check, money orders and most major credit cards. I hereby direct my insurance company to pay SWVPT all therapy benefits payable under my current plan. I understand that it is my responsibility to review details regarding my insurance plan's policies, co-pays, deductibles and in network providers. I agree to inform SWVPT immediately if there are any changes to my insurance policy. Although an insurance claim is filed, you will receive a monthly statement if your account has a balance due. I agree to pay SWVPT all charges in excess of those paid by my insurance company within 30 days of receipt. If you are unable to pay amount due in full, please contact either Krista or Patrick at (304) 855-9500 to initiate a payment plan that meets your financial needs.

Please notify a member of our staff if you would like a copy of this page for your records.