



# NEW PATIENT INTAKE FORM

PATIENT INFORMATION			
PATIENT'S FULL NAME (LAST, FIRST, MI)			
ADDRESS		CITY	STATE ZIP
BIRTH SEX ( ) Male ( ) Female	SSN		DOB (MM/DD/YYYY)
HOME PHONE OK TO CALL	CELL PHONE OK TO CALL	WORK PHONE OK TO CALL	
EMAIL		HOW DID YOU HEAR ABOUT US?	
REFERRING PHYSICIAN	ADDRESS		PHONE
EMERGENCY CONTACT NAME		RELATION	PHONE
INJURY/ILLNESS INFORMATION			
DIAGNOSIS	DATE OF INJURY (MM/DD/YYYY)		DATE OF SURGERY (MM/DD/YYYY)
NATURE OF INJURY/ILLNESS		TYPE OF INJURY ON THE JOB    MOTOR VEHICLE    OTHER	
PRIMARY INSURANCE INFORMATION			
PRIMARY INSURANCE COMPANY			PHONE NUMBER
SUBSCRIBERS NAME		SUBSCRIBERS DOB (MM/DD/YYYY)	RELATION
ID#	GROUP ID#	EMPLOYER / PHONE	
INSURANCE ADDRESS			
SECONDARY INSURANCE INFORMATION			
SECONDARY INSURANCE COMPANY			PHONE NUMBER
SUBSCRIBERS NAME		SUBSCRIBERS DOB (MM/DD/YYYY)	RELATION
ID#	GROUP ID#	EMPLOYER / PHONE	
INSURANCE ADDRESS			
GUARANTOR INFORMATION			
GUARANTOR NAME		PHONE	DOB
ADDRESS		CITY	STATE ZIP

I acknowledge that all the information that I have supplied on these forms is true, accurate, current, and complete.

# Superior Physical Therapy Medical Screening Questionnaire



Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

Are you latex sensitive? Yes No

Do you smoke? Yes No

Do you have a pacemaker? Yes No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

ALLERGIES: List any medication(s) you are allergic to: \_\_\_\_\_

---

**Have you RECENTLY noted any of the following (check all that apply)?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> fatigue                                      | <input type="checkbox"/> numbness or tingling                 | <input type="checkbox"/> constipation        |
| <input type="checkbox"/> fever/chills/sweats                          | <input type="checkbox"/> muscle weakness                      | <input type="checkbox"/> diarrhea            |
| <input type="checkbox"/> nausea/vomiting                              | <input type="checkbox"/> dizziness/lightheadedness            | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain                             | <input type="checkbox"/> heartburn/indigestion                | <input type="checkbox"/> fainting            |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> difficulty swallowing                | <input type="checkbox"/> cough               |
| <input type="checkbox"/> falls  | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> headaches           |

**Have you EVER been diagnosed with any of the following conditions (check all that apply)?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> cancer                                 | <input type="checkbox"/> depression                       | <input type="checkbox"/> thyroid problems      |
| <input type="checkbox"/> heart problems                         | <input type="checkbox"/> lung problems                    | <input type="checkbox"/> diabetes              |
| <input type="checkbox"/> chest pain/angina                      | <input type="checkbox"/> tuberculosis                     | <input type="checkbox"/> osteoporosis          |
| <input type="checkbox"/> high blood pressure                    | <input type="checkbox"/> asthma                           | <input type="checkbox"/> multiple sclerosis    |
| <input type="checkbox"/> circulation problems                   | <input type="checkbox"/> rheumatoid arthritis             | <input type="checkbox"/> epilepsy              |
| <input type="checkbox"/> blood clots                            | <input type="checkbox"/> other arthritic condition        | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke                                 | <input type="checkbox"/> bladder/urinary tract infection  | <input type="checkbox"/> ulcers                |
| <input type="checkbox"/> anemia                                 | <input type="checkbox"/> kidney problem/infection         | <input type="checkbox"/> liver problems        |
| <input type="checkbox"/> bone or joint infection                | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis             |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> pelvic inflammatory disease      | <input type="checkbox"/> pneumonia             |

**Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?**

- |  |                                     |   |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer              | <input type="checkbox"/> diabetes   | <input type="checkbox"/> tuberculosis     |
| <input type="checkbox"/> heart problems      | <input type="checkbox"/> stroke     | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots      |

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

If yes to either, is this something with which you would like help? YES YES, but NOT today NO

---

**Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):**

\_\_\_\_\_

\_\_\_\_\_

Have you ever taken steroid medications for any medical conditions? YES NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

\_\_\_\_\_

\_\_\_\_\_

What date (roughly) did your present problem start? \_\_\_\_\_

My symptoms are currently:  Getting Better     Getting Worse     Staying about the same

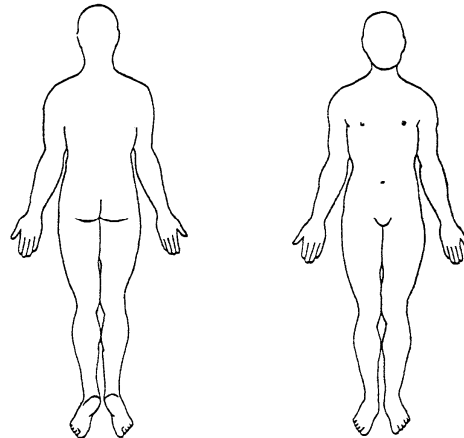
Treatment received so far for this problem (chiropractic, injections, surgery, etc): \_\_\_\_\_

Please list special tests performed for this problem (x-ray, MRI, labs, etc) \_\_\_\_\_

**Body Chart:**

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling



My symptoms currently:  Come and go     Are Constant     Are constant, but change with activity

Using the 0 to 10 the scale, with 0 being “no pain” and 10 being the “worst pain imaginable” please describe:

Circle your **current** level of pain while completing this survey: ...0...1...2...3...4...5...6...7...8...9...10...

Circle the **best** your pain has been during the past 24 hours: ...0...1...2...3...4...5...6...7...8...9...10...

Circle the **worst** your pain has been during the past 24 hours: ...0...1...2...3...4...5...6...7...8...9...10...

**Easing Factors:** Identify **up to 3** important positions or activities that make your symptoms *better*:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Aggravating Factors:** Identify **up to 3** important activities that you are unable to do or are having difficulty with as a result of your problem.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Therapist Use:**  
 Rating: \_\_\_\_  
 Rating: \_\_\_\_  
 Rating: \_\_\_\_  
 Average: \_\_\_\_

**Therapist Use:**

Unable to perform    0 1 2 3 4 5 6 7 8 9 10    Able to perform at same level as before injury (problem)

**How are you currently able to sleep at night due to your symptoms?**

No problem sleeping     Difficulty falling asleep     Awakened by pain     Sleep only with medication

**When are your symptoms worst?**     Morning     Afternoon     Evening     Night     After activity

**When are your symptoms the best?**     Morning     Afternoon     Evening     Night     After activity



**Consent to Treatment**

I consent to and authorize Professional Occupational & Physical Therapy to administrator rehabilitation therapy treatment. I understand and am informed that, as in the practice of medicine, rehabilitation therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform my provider of rehabilitation therapy about any health problems or allergies I have, as well as medications I am taking. I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or treatment results from the rehabilitation therapy.

**Electrical Stimulation Pad Policy**

I acknowledge that I have read and understand the Electrical Stimulation Pad Policy and agree to abide by its terms.

**Authorization to Release / Obtain Information**

I hereby authorize the release of my patient health care information for the purposes of treatment or payment, to my physician, insurance company, adjustor, attorney, or other health care organizations pertinent to my case. Further, I authorize Professional to obtain needed information from my physician, insurance company, adjustor, attorney and any other health care organization pertinent to my case. These correspondence can be made via mailings, telephone and/or facsimile.

**Insurance Eligibility**

Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time a claim is received. We provide you with the Initial information as it is outlined by your insurance company. It is your responsibility to fully understand your insurance benefits.

**Financial Responsibility**

Payment is due at the time of treatment. I agree to pay Professional all amounts that are due for services rendered which are not otherwise paid for by my insurance plan I on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due for services rendered including, without limitation, reasonable attorney's fees.

**Assignment & Release of Benefits**

I hereby appoint Superior Physical Therapy as my authorized representative, and assign to it my right, to file for, receive and recover any and all monies payable for the care which it rendered to me from any third party claims payment source, including my health insurer, Medicare, Medicaid or other governmental program (collectively, my "Plan"), while I was eligible to receive such claim payment. I authorize you to send and receive documentation related to my treatment to, and consent to your discussing my treatment with, my Plan." I also authorize SPT to take any and all actions necessary to assert and pursue my legal rights to receive such claim payment under the terms of my Plan through any appeals and/or grievances and/or litigation and/or arbitration available to me for such purpose. As the assignor of the foregoing payment amounts, I direct that such payment be sent by my Plan to SPT and, in the case that payment is made by my Plan to me, I agree to remit such payment in full to SPT not later than ten (10) days after my receipt.

The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information printed above.

\_\_\_\_\_  
Patient Signature (Parent/Guardian if patient under 18 years)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date



# SUPERIOR PHYSICAL THERAPY

## HIPAA Patient Information Consent Form

### Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Superior Physical Therapy. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

### Assignment of Benefits and Insurance Proceeds

I authorize payment of medical benefits to Superior Physical Therapy for services rendered. Superior Physical Therpay will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

### Patient Information Consent Form (HIPAA)

I have read and fully understand Superior Physical Therapy Notice of Information Practices. I understand that Superior Physical Therapy may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Superior Physical Therapy will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Superior Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Supeior Physical Therapy has 30 days to respond to my request.

### Release of Information

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

### Designated Individuals Authorization

I, \_\_\_\_\_, hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print "none" below.

Authorized Designees:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I have read and understand the above consents, assignment of benefits, release of information, and designated individuals authorization above.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ DATE: \_\_\_\_\_

**Description:** This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. Please circle the answers below that best apply.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

**MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT**

**1. Pain Intensity**

- (0) I can tolerate the pain I have without having to use pain medication.
- (1) The pain is bad, but I can manage without having to take pain medication.
- (2) Pain medication provides me with complete relief from pain.
- (3) Pain medication provides me with moderate relief from pain.
- (4) Pain medication provides me with little relief from pain.
- (5) Pain medication has no effect on my pain.

**2. Personal Care (washing, dressing, etc.)**

- (0) I can take care of myself normally without causing increased pain.
- (1) I can take care of myself normally, but it increases my pain.
- (2) It is painful to take care of myself, and I am slow and careful.
- (3) I need help, but I am able to manage most of my personal care.
- (4) I need help every day in most aspects of my care.
- (5) I do not get dressed, wash with difficulty, and stay in bed.

**3. Lifting**

- (0) I can lift heavy weights without increased pain.
- (1) I can lift heavy weights, but it causes increased pain.
- (2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
- (3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- (4) I can lift only very light weights.
- (5) I cannot lift or carry anything at all.

**4. Walking**

- (0) Pain does not prevent me from walking any distance.
- (1) Pain prevents me from walking more than 1 mile.
- (2) Pain prevents me from walking more than 1/2 mile.
- (3) Pain prevents me from walking more than 1/4 mile.
- (4) I can only walk with crutches or a cane.
- (5) I am in bed most of the time and have to crawl to the toilet.

**5. Sitting**

- (0) I can sit in any chair as long as I like.
- (1) I can only sit in my favorite chair as long as I like.
- (2) Pain prevents me from sitting more than 1 hour.
- (3) Pain prevents me from sitting more than 1/2 hour.
- (4) Pain prevents me from sitting more than 10 minutes.
- (5) Pain prevents me from sitting at all.

**6. Standing**

- (0) I can stand as long as I want without increased pain.
- (1) I can stand as long as I want but, it increases my pain.
- (2) Pain prevents me from standing more than 1 hour.
- (3) Pain prevents me from standing more than 1/2 hour.
- (4) Pain prevents me from standing more than 10 minutes.
- (5) Pain prevents me from standing at all.

**7. Sleeping**

- (0) Pain does not prevent me from sleeping well.
- (1) I can sleep well only by using pain medication.
- (2) Even when I take pain medication, I sleep less than 6 hours.
- (3) Even when I take pain medication, I sleep less than 4 hours.
- (4) Even when I take pain medication, I sleep less than 2 hour
- (5) Pain prevents me from sleeping at all.

**8. Social Life**

- (0) My social life is normal and does not increase my pain.
- (1) My social life is normal, but it increases my level of pain.
- (2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
- (3) Pain prevents me from going out very often.
- (4) Pain has restricted my social life to my home.
- (5) I have hardly any social life because of my pain.

**9. Traveling**

- (0) I can travel anywhere without increased pain.
- (1) I can travel anywhere, but it increases my pain.
- (2) My pain restricts my travel over 2 hours.
- (3) My pain restricts my travel over 1 hour.
- (4) My pain restricts my travel to short necessary journeys under 1/2 hour.
- (5) My pain prevents all travel except for visits to the physician/therapist or hospital.

**10. Employment / Homemaking**

- (0) My normal homemaking/job activities do not cause pain.
- (1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- (2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
- (3) Pain prevents me from doing anything but light duties.
- (4) Pain prevents me from doing even light duties.
- (5) Pain prevents me from performing any job or homemaking chores.

ODI © Jeremy Fairbank 1980, All rights reserved. ODI contact information and permission to use: MAPI Research Trust, Lyon, France. E-mail: [contact@mapi-trust.org](mailto:contact@mapi-trust.org) – Internet: [www.mapi-trust.org](http://www.mapi-trust.org)

Therapist Use Only		
Comorbidities:	Cancer Diabetes Heart Condition High Blood Pressure Multiple Treatment Areas	Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) Obesity Surgery for this Problem Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
		ICD Code: _____