Pasion Physical Therapy LLC

Patient Intake Form

Patient Information:

Last Name: _____ *First Name:* _____ *Sex:* _____

Date of Birth: _____ *SS#:* ____-____-____

Address: _____ *City:* _____ *State:* _____

Zip Code: _____ *Work#:* ( ) _____-_____ *Home#:* ( ) _____-_____

Email: _____ *Mobile#:* ( ) _____-_____

Marital Status: Single _____ *Married* _____ *Divorced* _____ *Widowed* _____ *Domestic Partner* _____

Employer's Name: _____ *Occupation:* _____

Physician's Name: _____ *Diagnosis:* _____

Injury: Work or Auto related? _____ *Allergies or Medical Precautions:* _____

Emergency Contact: _____ *Phone#:* ( ) _____-_____

Insurance Information:

Insurance Co. Name: _____ *Policy#:* _____

Address: _____ *City:* _____ *State:* _____ *Zip Code:* _____

Insured's Name: _____ *SS#:* ____-____-____ *Date of Birth:* _____

Address: _____ *City:* _____ *State:* _____ *Zip Code:* _____

Insured's Employer's Name: _____

I hereby accept responsibility for the cost of this examination or treatment in the event that the Insurance Company denies this claim. I hereby understand and agree to accept responsibility of the cancellation policy of this office. Giving 24 hour notice to cancel. If I am unable to comply but reschedule the appointment before and within the end of the week, no charge will be made. Otherwise a $30.00 fee will be charged for the missed session. (Please note that it is your responsibility- Insurance companies do not reimburse for missed appointments.

Patient's signature: _____

Date Signed: _____

Pasion Physical Therapy LLC

Patient Questionnaire/ History

Name: _____ *Date of Birth:* _____ _____*Right or*_____*Left handed*

What is your Chief Complaint? _____

_____

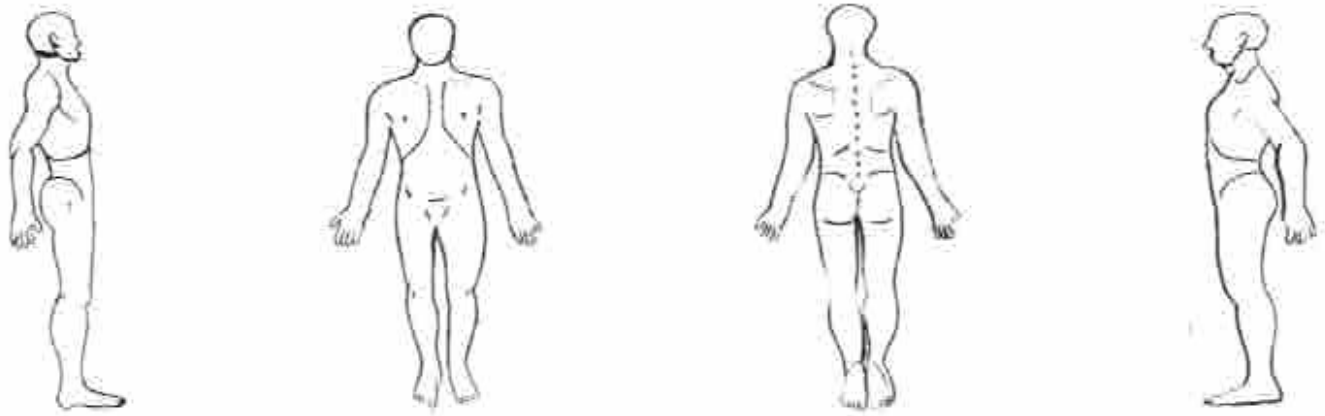
Rate your chief complaint in order of severity from worst (5) to least (1)

*Pain*____ *Decreased Motion*___ *Swelling/edema*____ *Stiffness*____ *Loss of function*_____

Where is your problem? Indicate on the body chart. Pain ___ *Numbness* ___ *Tingling* ___

Indicate the nature of your pain and symptoms: ___*Sharp* ___*Dull* ___*Piercing*___*Shooting* ___*Aching*

___*Deep* ___*Superficial* ___*Tingling* ___*Numbness* ___*Intermittent* ___*Burning* ___*Stabbing*



*When and how did this problem begin?*_____

_____

*What makes your symptoms/ pain worse?*_____

_____

What makes your symptoms/ pain lessen? _____

_____

Rate your pain on a visual scale (0-10) 0 no pain 10 excruciating pain: _____

*Worst it has been*_____ *Past 2 to 4 weeks*_____ *Past 24 hours*_____ *At this moment*_____

Are your symptoms worse in the: _____*Morning* _____*Afternoon* _____*Evening* _____ *Inconsistent*_____

Are your symptoms: _____*Improving* _____*Worse* _____*Stable*_____

Pasion Physical Therapy LLC

Medical History

*Has this problem affected your daily life or routine? Briefly describe in what ways.*_____

_____

_____

Have you had past similar episodes of this current problem? If yes, were you treated with: (circle disciplines, which apply) Physical Therapy, Acupuncture, M.D. (Meds, TPI's) Massage Therapist, Chiropractor, Pilates, General Exercise, exercise with trainer, Self medicated (Advil), ignored it, other. Did they help to alleviate your symptoms? _____

_____

Have you undergone any special tests for this condition? (X-rays, MRI's, ETC) If yes, do you know the results? _____

_____

Please answer the following questions:

	Yes	No
1) Do the current problems interrupt your sleep?		
2) Do your symptoms change with coughing or sneezing?		
3) Have you had any recent changes in bowel or bladder function?		
4) Do you experience any dizziness or vertigo?		
5) Have you had any recent change in your weight or appetite?		
6) Do you have any intolerance to hot or cold?		
7) Do you have any bruising or bleeding disorders?		
8) Have you had any skin changes, such as rashes or discoloration?		
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
10) Have you had a recent episode of nausea/vomiting?		
11) Are you pregnant?		
12) Do you have osteoporosis? Date of your last bone scan:		
13) Do you have any allergies?		
14) Have you noticed any shortness of breath or decrease in exercise tolerance?		
15) Do you use any assistive devise? (cane foot orthotics)		
16) Do you have high blood pressure?		
17) Do you have any cardiac problems?		
18) Do you have diabetes?		
19) Have you ever had cancer of any sort?		
20) Do you have a history of neck or back problems?		

Any other illness, past injuries I should be aware of? _____

Past surgeries___yes, ___no, give brief details: _____

List the medications you are currently taking (over the counter/prescription): _____

_____

Pasion Physical Therapy LLC

Social History

Are you presently working? _____Yes, _____No, since:_____

_____

Physical/Emotional demands of present occupation? (High, moderate, minimal)_____

_____

Overall activity level: _____Sedentary, _____Light, _____Moderate, _____Heavy, _____Very heavy.

Sports and Exercise (Type, Frequency, Duration) _____

_____

Use of Tobacco ____Yes, ____no. Use of Alcohol ____Yes, ____No.

Family medical History:

*Does any one in your immediate family (mother, father, siblings) have a history of Diabetes, High Blood Pressure, Cardiac Problems, or Cancer?*_____

_____

_____

Please list 3 goals of Physical Therapy and time frames:

1) _____
2) _____
3) _____

Who can we thank for this referral?

_____

Thank you

Pasion Physical Therapy LLC

Billing Policy, Release, and Authorization

I authorize Pasion Physical Therapy LLC to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Pasion Physical Therapy LLC. I authorize Pasion Physcial Therapy LLC to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatments. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

*Signature:*_____ *Date:*_____

PASION PHYSICAL THERAPY LLC

Office 1:
893 Cranbury South River Rd
Suite 201
Monroe Township, NJ 08831

Office 2:
Branchburg Commons
3322 Route 22 West,
Bldg 10 Suite 1007
Branchburg, NJ 08876

WRITTEN ACNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Patient: _____

I, _____ *hereby acknowledge that I have received a copy of The Notice of Privacy Practices.*

Signature: _____

Relationship to Patient (if patient is a minor): _____

Date: _____

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Dear Valued Patient:
The staff of Pasion Physical Therapy LLC is committed to improving its facilities and services provided to you. As a result, it has become necessary to implement a $30.00 late appointment cancellation fee for any scheduled appointments that are not cancelled within 24 hours, or for NO SHOWS.

Your cooperation is greatly appreciated.

Thank you
Pasion Physical Therapy LLC

I _____ have read and agree to the above terms and conditions.

_____
Date Signed