NEW PATIENT INTAKE FORM

Date: _____

Last Name:	First Name:
Date of Birth:	Gender: **Male** **Female**
Social Security Number: _____-____-_____	Email: _____
Address:_____ Apt # _____ City:_____ State:_____ Zip: _____	Home Phone: (_____) _____ Cell Phone: (_____) _____

Emergency Contact

Name:	Relationship:	Phone: (_____) _____

Employer Information

Employer:	Address:	Phone: (_____) _____

Insurance

Primary Insurance	
Name of Insurance:	ID Number:
Policyholder's Relation:	Policyholder's Date of Birth:
Secondary Insurance	
Name of Insurance:	ID Number:
Policyholder's Relation:	Policyholder's Date of Birth:

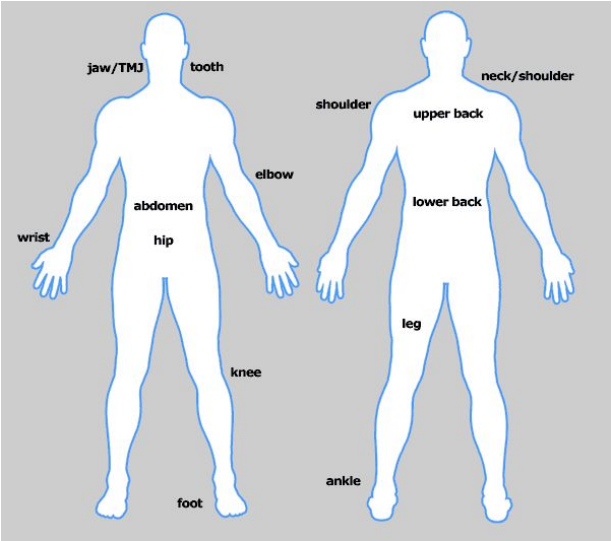
Responsible Party Information (Parent/Guardian must complete if patient is under 18)

Name:	Relationship:	Phone: (_____) _____
Date of Birth:	Address:	

Problem/Condition

Description of Problem: Date of Onset/Injury:	Primary Care Doctor: Surgeon and Date of Surgery:
Referred By:	

Please mark on the drawing below where you feel pain.



Is this injury/illness due to any of the following: Circle: **Work Auto Accident Other N/A**

Have you ever been treated at Golden Hills Physical Therapy? Circle: **Yes** or **No.**

If yes, when: _____.

Have you had physical therapy, occupational therapy or chiropractic treatment this year for this condition? Circle: **Yes or No.** *If yes, please indicate the type of treatment and the duration of treatment:* _____.

How did you hear about us? Circle: **Physician Family/Friends Social Media Other: _____**

Accident Injuries ONLY:

Name of Insurance: _____	Adjuster:_____	Attorney:_____
Claim Number: _____	Phone: (_____) _____	Phone: (_____) _____
Date of Accident: _____	Fax: (_____) _____	Fax: (_____) _____
State of Accident: _____	E-Mail:_____	E-Mail:_____
Additional Details:		

Medicare Patients ONLY:

When did you last receive HOME HEALTH CARE, HOSPICE CARE or care in a SKILLED NURSING FACILITY? _____

If yes, please provide the name and phone number of the Home Health Agency:
Name: _____ Phone Number: _____

CONSENT TO TREAT: I consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, 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 the treatment results from the rehabilitation therapy.

Signature of Patient or Legal Guardian: _____ Date: ____/____/_____

FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS: I certify that all the information I have provided is accurate and I understand that providing misinformation will result in the delay of my claims being processed and or result in me being liable to GHPT for all my visits. I understand that I am financially responsible for my medical bills incurred while receiving Physical Therapy Services at Golden Hills PT (GHPT). I agree to pay GHPT all amounts that are due and owing for services rendered by our facility which are not otherwise paid for by Medicare, a third party insurance plan, a third party payer, or other payer source 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 and owing for services rendered by our facility including, without limitation, reasonable attorney's fees. I also understand that GHPT will submit my insurance claims as a courtesy to me, but this does not relieve from my financial responsibility to GHPT. I hereby authorize payment of medical benefits directly to GHPT for services rendered. I further authorize the release of any medical information necessary to process any insurance claim on my behalf. I permit a copy of this authorization to be as valid as the original. Where applicable I authorize filing a Lien against any and all third party liability action relating to the need for treatment including the worker compensation cases. I also understand that I am financially responsible for any and all non-covered charges, deductible and co-pays. I also agree that if for any reason my insurance does not cover physical therapy services I will pay for all charges. By signing below I authorize GHPT to treat the above name patient. I acknowledge that I have read and understand all of the above terms. I authorize GHPT to assign their rights under this contract to a third party. **COPAYMENT IS DUE AT THE TIME OF SERVICE.**

Signature of Patient or Legal Guardian: _____ Date: ____/____/_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT:

I understand that, under the Health Insurance Portability Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I acknowledge that I have received your Notice or Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice or Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain current copy of the Notice or Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature of Patient or Legal Guardian: _____ Date: ____/____/_____

CANCELLATION/ NO SHOW POLICY:

Late Arrival Policy: If you are late for an appointment, you will be seen as soon as we can possibly accommodate you, and for the length of time remaining to your appointment. If you are over 20 minutes late to your appointment, you may have to be rescheduled and you will be charged a $25 fee. **Initial_____**

Cancellation Policy: If you need to cancel an appointment, please call us ASAP (24 hours notice) so we have the opportunity to offer your appointment to another patient. If less than 24 hours notice is given, you will be charged a $25 cancellation fee. **Initial_____**

No Show Policy: If you do not show up for a scheduled appointment, you will be charged a $50 no show fee. **Initial_____**

Repeated late cancellations or no-shows are disruptive to the optimal delivery of care to you and our other patients. Missed appointments prevent other patients from coming in at the same time and affect the consistency of your own rehabilitation program. As a result, 3 late cancellations or no shows will result in discontinuing physical therapy at Golden Hills Physical Therapy. In the event that you are discharged from our care, your referring provider or case manager will be notified of the reason for discharge from physical therapy. I understand the terms of this form. I realize that I am financially responsible for charges incurred from cancellations or no shows.

Signature of Patient or Legal Guardian: _____ Date: ____/____/_____

PHOTOGRAPHY CONSENT FORM / RELEASE:

I, (print name)_____, hereby grant permission to Golden Hills Physical Therapy representatives, to take and use: photographs, video, and/or digital images of me for use in news releases and/or educational materials.

If patient is a minor (under age of 18): I, (print name) _____, parent or official guardian of (child's name)_____hereby grant permission to Golden Hills Physical Therapy representatives, to take and use: photographs, video, and/or digital images of my child for use in news releases and/or educational materials.

These materials may include printed or electronic publications, Web sites or other electronic communications. I authorize the use of these images without compensation to me. All negatives, prints, and digital reproductions shall be the property of Golden Hills Physical Therapy.

Signature of Patient or Legal Guardian: _____ Date: ____/____/_____

FOTO Patient Intake Form
Lower Back

Staff to Complete

PATIENT NAME:_____ Patient ID: _____

Gender: Male / Female Date of Birth: _____ / _____ / _____ Clinician: _____

Body Part _____ Impairment _____ Care Type _____

Payer Source _____ *(Type of Plan such as Preferred Provider, HMO, WC, Auto Insurance, etc.)*

Date of Survey: ____ / ____ / _____

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

Today, because of your back problem, do you or would you have any difficulty at all…	**Unable to perform**	**Extreme difficulty**	**Quite a bit of difficulty**	**Moderate difficulty**	**A little bit of difficulty**	**No difficulty**
1. Performing any of your usual work, housework, or school activities?						
2. Performing your usual hobbies, recreational, or sporting activities?						
3. Performing heavy activities around your home?						
4. Bending or stooping?						
5. Lifting a box of groceries from the floor?						
Does or would your back problem limit:	**Yes, limited a lot**	**Yes, limited a little**	**No, not limited at all**			
6. Vigorous activities like running, lifting heavy objects, participating in strenuous sports?						
7. Moderate activities like moving a table, pushing a vacuum cleaner, bowling, or playing golf?						
8. Lifting or carrying items like groceries?						
9. Attending social events?						
10. Getting in and out of a chair?						

11. Rate the level of pain you have had in the last 24 hours (*please circle response*):

0 1 2 3 4 5 6 7 8 9 10

(None) (Pain as bad as it can be)

12. Please indicate the number of surgeries for your primary condition. ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4+

13. How many days ago did the condition begin? ☐ 0-7 days ☐ 8-14 ☐ 15-21 ☐ 22-90 ☐ 91 days to 6 mos. ☐ Over 6 mos. ago

14. Are you taking prescription medication for this condition? ☐ Yes ☐ No

Patient Name: _____ Patient ID _____

15. Have you received treatments for this condition before? ☐ Yes ☐ No

16. How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? ☐ At least 3 times a week ☐ Once or twice per week ☐ Seldom or never

17. Other health problems may affect your treatment. Please check (✓) any of the following that apply to you:

- ☐ Arthritis (rheumatoid / osteoarthritis)
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema
- ☐ Angina
- ☐ Congestive heart failure (or heart disease)
- ☐ Heart attack (Myocardial infarction)
- ☐ High blood pressure
- ☐ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
- ☐ Stroke or TIA
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Diabetes Types I and II
- ☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ☐ Visual impairment (such as cataracts, glaucoma, macular degeneration)
- ☐ Hearing impairment (very hard of hearing, even with hearing aids)
- ☐ Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- ☐ Kidney, bladder, prostate, or urination problems
- ☐ Previous accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Other disorders
- ☐ Hepatitis / AIDS
- ☐ Prior surgery
- ☐ Prosthesis / Implants
- ☐ Sleep dysfunction
- ☐ Cancer

18. Height: _____ ft. _____ in. Weight: _____ lbs.

19. This is a statement other patients have made.
"I should not do physical activities which (might) make my pain worse."
Please rate your level of agreement with this statement.
- ☐ Completely Disagree
- ☐ Somewhat Disagree
- ☐ Unsure
- ☐ Somewhat Agree
- ☐ Completely Agree

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204