HANDS-ON Physical Therapy Initial Intake

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Name Birth date Social Security # Date

Address (Street) CityState Zip

Profession Home Phone Cell Phone Work Phone

Email Insurance Subscriber's Name Subscriber's Date of Birth

How did you hear about HANDS-ON Physical Therapy? ______

Present symptoms: What is your major complaint or condition you want to improve? ______

______

______

When did you first notice major complaints? ______

What brought it on? ______

How often are your symptoms present? (Please circle or check)
1. Constantly (76–100% of the day) 2. Frequently (51–75%)
3. Occasionally (26–50% of the day) 4. Intermittently (0–25%)

Describe the nature of your pain: (Please circle or check)
1. Sharp 2. Dull Ache 3. Numb 4. Shooting 5. Burning 6. Tingling

What activities aggravate the condition? ______

Improve the condition? ______

Is the condition getting progressively worse? Yes No

Please explain ______

______

Does the condition interfere with your sleep? Yes No

What were you able to do before these symptoms began that you cannot do now? ______

______

What limits do you have to set on your normal activities due to this problem?

Activity	Any time limits?	Any special modifications?
Sitting		
Standing		
Walking		
Lifting		
Computer use		
Driving		
Recreation (list):		

Have you ever had x-rays, MRI, CT Scan for your area of complaint? Yes No

Please explain ______

Who have you seen for this condition before today? 1. Medical Doctor 2. Massage Therapist 3. Chiropractor
4. Acupuncturist 5. Physical therapist 6. Other ______

What are you currently doing for self-care of your symptoms? ______

______

Medications: ______

______

What specific results do you want from your therapy in your body and in your life? ______________________

____

What are your functional goals (Be able to reach into lower cupboard without pain. Be able to drive longer. Be able to garden again. Be able to dress without pain)? ______________________

____

____

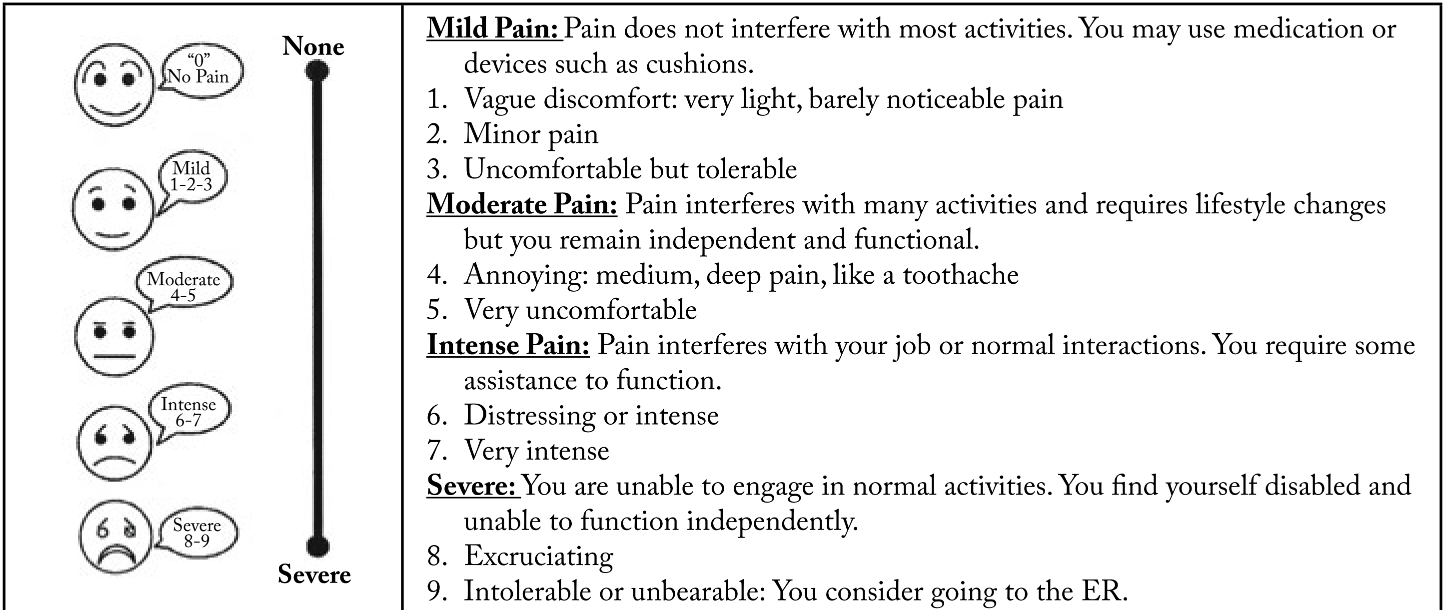
Please list any additional comments regarding your health and well-being: ______________________

____

0-9 Pain Scale

Please use the following information when rating your pain.

Draw an 'X' on the vertical line to indicate the intensity of your pain.



Mild Pain: Pain does not interfere with most activities. You may use medication or devices such as cushions.

1. Vague discomfort: very light, barely noticeable pain
2. Minor pain
3. Uncomfortable but tolerable

Moderate Pain: Pain interferes with many activities and requires lifestyle changes but you remain independent and functional.

4. Annoying: medium, deep pain, like a toothache
5. Very uncomfortable

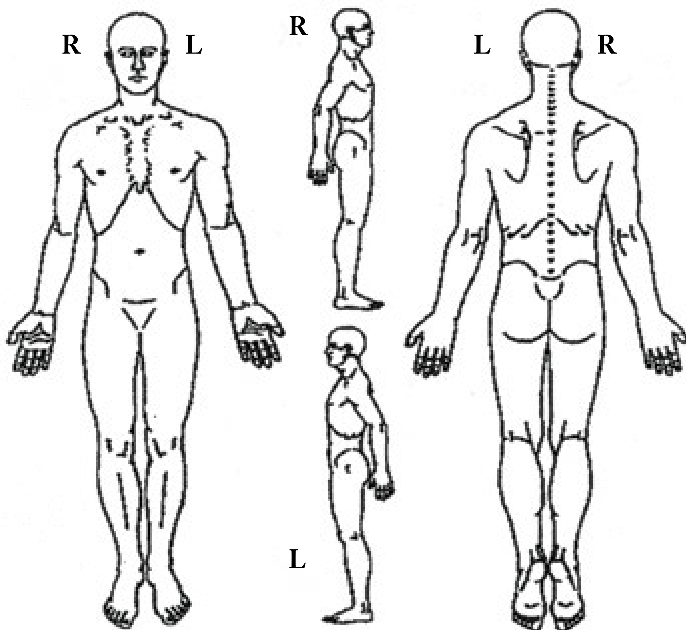
Intense Pain: Pain interferes with your job or normal interactions. You require some assistance to function.

6. Distressing or intense
7. Very intense

Severe: You are unable to engage in normal activities. You find yourself disabled and unable to function independently.

8. Excruciating
9. Intolerable or unbearable: You consider going to the ER.

Please indicate, on the figures below, the area(s) in which you are experiencing symptoms:



Please list your most painful areas and rate them using the 0-9 scale above

1. Primary Area______________________
Usual pain level:__________
Lowest pain level in past week:__________
Highest pain level in past week:__________
% of time at highest pain level:__________

2. Secondary Area______________________
Usual pain level: __________
Lowest pain level in past week: __________
Highest pain level in past week: __________
% of time at highest pain level: __________

3. ______________________
Usual pain level: __________
Lowest pain level in past week: __________
Highest pain level in past week: __________
% of time at highest pain level: __________

What % of time are you pain free? ________%

Patient Name: ______________________ Date:__________

Hands-On Physical Therapy Health History Questionnaire

Please indicate if you now have, or in the past had, any of the following (check all that apply).

Nervous System

- ○ Head / Brain injury
- ○ Stroke / TIAs
- ○ MS / Parkinson's
- ○ Peripheral neuropathy
- ○ Epilepsy / Seizure disorder
- ○ Other

Endocrine & Immune System

- ○ AIDS / HIV positive
- ○ Hepatitis A B C
- ○ Diabetes type 1 or 2
- ○ Thyroid imbalance
- ○ Low blood sugar
- ○ Cancer
- ○ Other

Cardiac / Circulation System

- ○ Heart attack
- ○ Angina or chest pain
- ○ Irregular heart rhythm
- ○ Stents placed
- ○ Bypass surgery
- ○ Pacemaker or defibrillator
- ○ Aneurism
- ○ Blood clot
- ○ Bleeding / Bruising tendency
- ○ Deep vein thrombosis (DVT)
- ○ High blood pressure
- ○ High cholesterol

Respiratory System

- ○ Asthma
- ○ Emphysema or COPD
- ○ Pneumonia
- ○ Sinus surgeries / Deviated septum
- ○ Allergies
- ○ Other lung problem

Traumas

- ○ Bad falls
- ○ Dislocations
- ○ Ligament tears
- ○ Meniscus tears
- ○ Motor vehicle accident
  1. When?
  2. When?
  3. When?

Musculoskeletal System

- ○ Osteoarthritis
- ○ Spinal stenosis
- ○ Spondylolisthesis
- ○ Herniated disc – neck
- ○ Herniated disc – low back
- ○ Osteoporosis / Osteopenia
- ○ Fractures
- ○ Carpal tunnel syndrome
- ○ Thoracic outlet syndrome
- ○ Rheumatoid arthritis
- ○ Lupus
- ○ Gout
- ○ Fibromyalgia
- ○ Migraine
- ○ Frequent headaches
- ○ TMJ
- ○ Lyme disease
- ○ Other

Digestive & Pelvic Health

- ○ IBS
- ○ Frequent diarrhea
- ○ Frequent constipation
- ○ Urinary incontinence
- ○ Bowel leakage
- ○ Pelvic organ prolapse
- ○ Interstitial cystitis
- ○ Endometriosis
- ○ Pelvic pain
- ○ Other

Surgeries

Please list all surgical procedures with the approximate date or your age at the time.

Patient Name: ______________________ Date:__________

HANDS-ON Physical Therapy

Financial Agreement, Assignment of Benefits, Patient Consent Form & Policies

With the execution of this document, the undersigned, in consideration for services rendered, herby agree to the following:

1. **Financial Agreement:** I agree to pay for all services rendered to me by HANDS-ON Physical Therapy (also referred to as HANDS-ON Therapy or Christine McKnight, PT). I understand that as a courtesy to its patients providing insurance/billing information, HANDS-ON Physical Therapy will submit claims to my health care plan or insurance company. I further understand, however, that I am responsible for payment of the balance owed. I agree that I am also responsible for any deductibles, coinsurance, copays, charges for noncovered services, charges deemed "medically unnecessary" or charges for which I have not obtained a properly authorized written referral, if required of my health plan. In the event that I am not currently enrolled as a member of a health care plan, I am personally responsible for all charges incurred for services.
2. **Assignment of benefits:** I hereby assign to HANDS-ON Physical Therapy those insurance benefit payments due HANDS-ON Physical Therapy, and herby authorize my insurance company to make payment directly to HANDS-ON Physical Therapy or Christine McKnight, PT. I understand that, regardless of this assignment, I remain primarily responsible to HANDS-ON Physical Therapy for payment of all actual charges. A carbon copy or photocopy of this assignment shall be as valid as the original.
3. **Release of information:** I authorize HANDS-ON Physical Therapy to disclose all or part of my medical record to any insurance carrier, person, or corporation that is or may be liable under contract to HANDS-ON Physical Therapy, or to me, or to a family member or employer of mine, for all or part of HANDS-ON Physical Therapy's charges. This authorization includes but is not limited to, workers' compensation carriers, Anthem (Blue Cross), Blue Shield, commercial insurance carriers, and the fiscal intermediary under Medicare and Medicaid.
4. **Patient consent:** Based on physician's referral for HANDS-ON Physical Therapy's services, I request and give consent to HANDS-ON Physical Therapy, its therapists, and staff to provide therapeutic services and related care.

Client & Therapist Agreement

The mission of HANDS-ON Physical Therapy is to create a healing experience through hands-on techniques, movement education, and open communication, while providing an environment that fosters each client's innate healing capacity.

I will communicate any changes in health insurance, address, phone number, or health condition as soon as possible.

I will give 48 hours' notice if I need to cancel or reschedule an appointment. HANDS-ON Physcial Therapy charges a missed appointment fee when 48 hours' notice is not given; this fee is $25 for 30-minute appointments and $50 for 60-minute appointments.

I understand I may be released from care if missed visits interfere with the therapist's ability to provide appropriate and effective treatment.

I understand that everyone in this office will safeguard all patient files and information against loss, tampering, or use by unauthorized persons including any computerized information.

I understand that photographs may be taken as a visual aid for both myself and for my provider.

I authorize HANDS-ON Therapy to request any medical records pertaining to my treatment.

Any co-insurance or deductibles are due as incurred.

I have received the Notice of Privacy Practices and have been provided an opportunity to review it by HANDS-ON Physical Therapy.

My signature below acknowledges that I have been given the opportunity to read or have had the above information explained to me and that I fully understand the statements in this document and consent to each of them. I certify that I am the patient or am duly authorized by the patient to execute the above and I accept the terms.

Patient Name: ____

Patient Signature ______________________________ **Date** ______________

Patients' agent/representative/ guardian ___ Patient name:______________________ Date: ______________