**Intake Form for Physical Therapy, Therapeutic Sciences, and Wellness Services**

**Patient Information**

\***Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \***Age**\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\***Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to text or call? Yes or No

\***Email** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation/Sport\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\***What brings you in today** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Pain Onset (injury)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*OK to use provided information to text/call/email you about therapy? Yes or No**

**OK to contact via social media? Yes or No**

**\*Describe/list activities that are challenging and/or limited due to pain or weakness. How does this limit your activity?**

**\*What are your health and wellness goals? What do you hope to be able to accomplish?**

**\*Have you had physical or occupational therapy or chiropractic care in the past year for this issue? Y N**

**If so, where and what was the outcome?**

I, the undersigned, certify that the above information provided herein is true and correct to the best of my knowledge, under penalty of law. I also agree to pay cash, check, or electronically at time of service but that I have a 100% money back guarantee.

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

Parent or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Health Questionnaire for Physical Therapy, Therapeutic Sciences, and Wellness Services**

Do you experience any of the following symptoms or have any of the following diagnoses?

1. Anemia Y
2. **Arthritis** Y
3. **Cancer** Y
4. Cardiovascular: **Pacemaker** Y **High/Low Blood Pressure** Y **CAD** Y
5. Fevers/Chills/Sweats Y
6. **Diabetes** Y
7. Depression Y
8. Hepatitis/HIV Y
9. Unexplained weight Loss/Gain Y
10. Malaise (feeling generally unwell) or unusual fatigue Y
11. **Fracture(s)** Y
12. Nausea/vomiting Y
13. **Headaches** Y
14. **Dizziness/ Lightheadedness/Loss of consciousness/Blurred vision** Y
15. **Numbness/Tingling** Y
16. Weakness Y
17. Muscle cramping Y
18. Chest pain/Palpitations Y
19. Swelling in feet or hands Y
20. Difficulty breathing/Shortness of breath Y
21. Cough/Change in cough/Blood in phlegm Y
22. Asthma Y Wheezing Y COPD Y
23. Difficulty swallowing Y Heartburn/Indigestion Y
24. Changes in Bowel pattern (color, texture, frequency) Y
25. **Possibility of pregnancy** Y

I ATTEST THAT IF I DID NOT MARK “Y” to indicate “YES” TO ANY OF THE ABOVE DIAGNOSES THEN I, TO THE BEST OF MY KNOWLEDGE, DO NOT HAVE IT.

Other relevant medical conditions or prior surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke/use tobacco? Y N

Patient/Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party’s relationship to the Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent form for Physical Therapy, Therapeutic Sciences, and Wellness Services**

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a physician? Y N
2. If no, do you want referral to a physician? Y N
3. If so, do you want the information collected from the examination and evaluation conveyed to your physician? Y N
	1. If so I will send the information collected during the examination within 5 business days. I will also consult with your physician within the first 6 visits or within 15 business days from the initial consult/examination.
4. Have you been diagnosed or seen by your physician for this issue in the past 12 mos? Y N
	1. I understand that if I do not have a physician or if my physician has not been notified, physical therapy services for this issue cannot continue beyond 30 days.
5. I, the undersigned, understand that if there is not improvement in symptoms within 6 visits or 15 business days from initiation of physical therapy that it is recommended that I seek the advice of a licensed physician unless the issue has been previously diagnosed by the licensed physician. Also, I understand that if the issue resolves but returns within 90 days then an immediate referral will occur.
6. I understand that referral will occur if presenting symptoms suggest diagnosis outside the physical therapist’s scope of practice.
7. I understand that services rendered here are directed toward prevention and enhancement of “normal” physiology, and not physical therapy per se, unless a referral is made from your physician. I, the undersigned, also understand that Dr. Jacob Hamrick recommends getting a referral from your licensed physician prior to treatment.
8. Informed Consent: The purpose of physical therapy is to treat disease, injury, and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. The practice of Wellness Sciences (training) is to promote optimal health through a variety of interventions. All procedures will be thoroughly explained to you before you are asked to perform them. I hereby consent to and authorize Dr. Jacob Hamrick to evaluate and administer physical therapy treatment and training to my condition. I understand and am informed that, as in the practice of medicine, physical therapy and training may have some risks and, although unlikely, may aggravate my condition. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. The physical therapist has fully explained to me the nature and purposed of the procedures, evaluation, and course of treatment, and has witnessed my signature of this consent in his presence. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking. Should you feel any discomfort or pain or have other unresolved concerns it is your right to decline any part of your treatment or training at any time before or during treatment.
9. Waiver and Release: I hereby release, discharge and acquit Dr. Jacob Hamrick, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, EMT, physician, or urgent care services.
10. Minor Patients: The parent or guardian accompanying a minor is responsible for payment of services. Unaccompanied minors (under 18) will be denied non-emergency treatment, unless the parent or guardian has signed patient and financial responsibility forms.
11. Release of Information: Dr. Jacob Hamrick may release patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
12. No Guarantees: I understand that the practice of physical therapy is not an exact science and that no guarantees have been made to me as a result of treatments or examinations by the physical therapist or supportive staff. I understand that no contract, guarantee, warranty, or promise concerning the results of the physical therapy services is made.
13. Collections: If your account becomes delinquent, collection proceedings will occur and you will be 100% liable for any collection fees, attorney and court costs incurred by Dr. Jacob Hamrick to collect said fees from the Responsible Party.
14. Returned Checks/Liens: Returned checks are subject to a $25.00 administrative charge as well as the bank’s charge for bounced checks. Any liens will be subject to a $20.00 co-payment for each visit. In addition, the account will incur a 1.5% interest charge for balances >30 days.
15. No Show/Cancel/Late Policy: Cancellations with less than 24 hrs notice will result in a $30.00 fee. Cancellations with less than 12 hrs notice or no notice will result in a $45.00 fee. If you arrive late for your appointment, the therapists may not have the time to treat you or your therapy time may be reduced.
16. Liability: I know and agree that Dr. Jacob Hamrick is not responsible for loss of damage to personal valuables.
17. The undersigned patient or Responsible Party acknowledges that he/she has read, understands, and agrees to the risks involved in physical therapy and training and to the information printed above and agrees to fully cooperate, participate in all physical therapy and training procedures, and comply with the established plan of care.

Patient/Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed evaluation and treatment have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Physical Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notice of Privacy Policies: HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CONTENT BELOW CAREFULLY.

Introduction: Dr. Jacob Hamrick is committed to treating and using your protected health information in a responsible manner. Federal and state laws require me to maintain the privacy of your protected health information. This Notice of Health Information Practices describes the personal information that I collect, and how and when I use or disclose this information. It also describes your rights as they relate to your protected health information (PHI). This Notice is effective as of April 14, 2003, and applies to all protected health information as defined by federal guidelines and regulations.

Understanding Your Health Record/Information: Every time you are treated by Jacob Hamrick a typed and/or written record of your visit is made. This note contains your symptoms, examination findings, and test results, treatment, and a plan of care for future visits. This information, is referred to as your health or medical record, and it serves as: 1) a basis for planning your care and treatment, 2) a means of communication among many healthcare professionals that work as a team to deliver care, 3) a legal document described the care you received, 4) a means by which a third party payer can verify that services billed were actually provided, 5) a tool in educating health professionals, 6) a source of information for public health officials charged with improving the health of this state and nation, 7) a source of data for planning and marketing, 8) a tool with which I can assess and continually work to improve the care I render and the outcomes I achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand, who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights: Although your health record is the physical property of Jacob Hamrick, the information belongs to you. You have the right to: 1) obtain a copy of this notice of information practices on request, 2) inspect and receive a copy of your health record as provided for in 45 CFR 164.524, 3) amend your health record as provided in 45 CFR 164.528, 4) obtain an accounting of disclosures of your health information other than for treatment, payment and healthcare operations as provided in 45 CFR 164.528, 5) request communications of your health information by alternative means or at alternative locations, 6) request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and 7) revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Dr. Jacob Hamrick is required to: 1) maintain the privacy of your health information, 2) provide you with this notice as to our legal duties and privacy practices with respect to information that is collected and maintained about you, 3) abide by the terms of this notice, 4) notify you if I am unable to agree to a requested restriction, and 5) accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Dr. Jacob Hamrick reserves the right to change practices and to make the new provisions effective for all protected health information that is maintained. Should information practices change, Dr. Jacob Hamrick will mail a revised notice to the address you provided on file, or based on agreement, a copy will be emailed to you.

Notification: Dr. Jacob Hamrick may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. As a means of communication we may: leave a message on your answering machine or on voicemail, mail you a postcard or written notice, and email you, your healthcare provider, or case manager.

Public Health: As required by law, Dr. Jacob Hamrick may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

I consent to the use or disclosure of my protected health information (PHI) by Dr. Jacob Hamrick for the purpose of Treatment, Payment, and Health Care Operations. I have read a copy of the Notice of Privacy Practices: HIPAA and understand I have a right to review it prior to signing this document.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Photography Consent**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do hereby give consent and authorization for Proactive Alliance Therapy and Wellness (PATW) to utilize photographs of my medical condition/status/progress and self for documentation or promotion (as requested by PATW). PATW has my permission to use these at the discretion of PATW and who they might employ. I understand that should I choose to rescind this authorization; I may do so verbally or in writing.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_