THERAPIST: ____________________ DATE / TIME: ____________________

INTAKE DATE

PATIENT INFORMATION

LAST NAME	FIRST	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX

HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE
MAILING ADDRESS	CITY	STATE	ZIP CODE	CELL PHONE

WORK ADDRESS	WORK PHONE

MARITAL STATUS SINGLE ( ) MARRIED ( ) OTHER ( )	HAVE YOU BEEN TREATED AT THIS OR ANY OTHER PHYSICAL THERAPY CLINIC BEFORE? IF YES, WHERE?

EMPLOYMENT STATUS EMPLOYED ( ) FULL TIME STUDENT ( ) PART TIME STUDENT ( ) N/A ( )	EMPLOYER NAME / SCHOOL NAME	TITLE / POSITION

REFERRING / PRIMARY PHYSICIAN INFORMATION

REFERRING: LAST NAME	FIRST	MI	ADDRESS	TELEPHONE
PRIMARY: LAST NAME	FIRST	MI	ADDRESS	TELEPHONE

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME	FIRST NAME	MI

ADDRESS	STATE	ZIP CODE

HOME PHONE	WORK PHONE

EMERGENCY CONTACT RELATIONSHIP: SPOUSE ( ) PARENT ( ) GUARDIAN ( )	PARENT OR GUARDIAN E-MAIL ADDRESS

REASON FOR TODAY'S VISIT

IS THIS INJURY / CONDITION RELATED TO YOUR ...

JOB:	CAR:	HOME:	OTHER ACCIDENT:
YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )

PLEASE INDICATE THE DATE OF ACCIDENT/ INJURY:	PLEASE INDICATE THE DATES OF THE SURGICAL PROCEDURE

PLEASE INDICATE THE DATE OF YOUR LAST DOCTOR'S VISIT:	TELEPHONE:

PLEASE DESCRIBE THE INJURY / ACCIDENT / OR REGION OF SYMPTOMS:

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

RESPONSIBLE PARTY SIGNATURE	TODAY'S DATE / /

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE	PHONE

POLICYHOLDER (if other than patient)	SEX	DATE OF BIRTH

SOCIAL SECURITY NUMBER (of policyholder)	PHONE NUMBER (of policyholder)	RELATIONSHIP TO PATIENT

NOTES:

SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE	PHONE

POLICYHOLDER (if other than patient)	SEX	DATE OF BIRTH

SOCIAL SECURITY NUMBER (of policyholder)	PHONE NUMBER (of policyholder)	RELATIONSHIP TO PATIENT

DO YOU FILE SECONDARY CLAIMS ELECTRONICALLY AFTER MEDICARE?

MOTOR VEHICLE ACCIDENT INFORMATION

INSURANCE COMPANY NAME	CLAIM NUMBER	

ADDRESS	CITY	STATE	ZIP CODE	PHONE

POLICYHOLDER (if other than patient)	Has report been filed?	MED-PAY AVAILABLE?

CONTACT PERSON	PHONE NUMBER (of policyholder)	PIP AVAILABLE? AMOUNT $

OTHER:

WORKER'S COMPENSATION INFORMATION

INSURANCE COMPANY NAME	CLAIM NUMBER	

ADDRESS	CITY	STATE	ZIP CODE	PHONE

CONTACT PERSON:	Has report been filed?	

UTILIZATION REVIEWER:	U.R. PHONE NUMBER:	

EMPLOYER INFORMATION:

NOTES:

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREATMENT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO **ORTHOPEDIC & SPORTS PHYSICAL THERAPY OF CAPE COD** IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IN THE EVENT MY ACCOUNT BECOMES DELINQUENT AND IS THEREFORE IN DEFAULT OF PAYMENT, I ACCEPT RESPONSIBILITY FOR THE PRINCIPAL AMOUNT OWING AS WELL AS ALL REASONABLE COSTS ASSOCIATED WITH THE COLLECTION OF THIS DEBT. THIS INCLUDES BUT IS NOT LIMITED TO COLLECTION SERVICE FEES, ATTORNEY'S FEES, AND ALL COURT COSTS AND ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT. INTEREST MAY BE CHARGED AT A RATE OF 1.5% PER MONTH (18% ANNUALLY) FOR UNPAID BALANCES OVER THIRTY DAYS OLD. IF REIMBURSEMENT IS MADE BY OTHER PAYER SOURCES, I.E. ATTORNEYS, ATTORNEY LIENS, OR THIRD PARTY INSURANCES, NEGOTIATED INSURANCE DISCOUNTS WILL NOT APPLY. PAYMENT IN FULL PER THE CLINIC'S FEE SCHEDULE IS EXPECTED. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF **ORTHOPEDIC & SPORTS PHYSICAL THERAPY** AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE.

AUTHORIZED SIGNATURE: X	TODAY'S DATE: / /

OSPT Orthopedic & Sports Physical Therapy of Cape Cod

NAME: ___________________________________

MEDICARE REQUIRED:
HEIGHT:_________(inches) WEIGHT: _______ (lbs)

Patient History Form

ALL PATIENTS: *PLEASE COMPLETE ALL INFORMATION FOR A THOROUGH MEDICAL HISTORY – YOUR ENTIRE MEDICAL HISTORY IS RELEVANT AND IS REQUIRED BY YOUR INSURANCE COMPANY UNDER NEW REGULATIONS / OBAMACARE

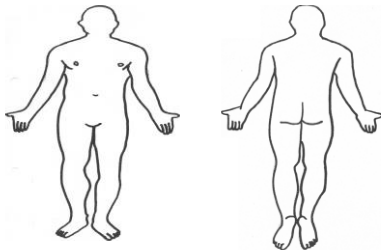
1) Please describe the problem/reason that brings you to physical therapy today: ______________________________
____

2) When did this problem first begin? (specific date): _____/ _____/_____ (insurance requirement)

3) Is **this problem** a result of: (please check each one)
a) a fall: _____ **YES** _____ **NO**
b) a work related injury : _____**YES** _____ **NO**
c) a motor vehicle accident: _____**YES** _____**NO**

4) Were you hospitalized or did you undergo surgery as a result of this problem/injury? (please circle) **YES** **NO**
a) **if YES** please provide the date of surgery or hospitalization: _____/_____/_____
b) **if YES** describe the surgery: ____

5) Please complete the following concerning your pain symptoms:
a) Shade in areas of pain:



b) Rate your pain with a number between 0 and 10 throughout the day: (Insurance Requirement)
***Pain scale 0-10* ; 0= no pain 10=need to go to hospital**
_____ morning _____midday
_____evening _____while sleeping

6) Please list **all** prior hospitalizations and/or surgery dates in your lifetime: (Insurance Requirement)
If you have a list we will gladly make a copy.

DATE:	REASON FOR HOSPITALIZATION &/or SURGERY:
_______	____
_______	____
_______	____
_______	____
_______	____

****PLEASE CONTINUE ON BACK SIDE OF THIS FORM*→

OSPT Orthopedic & Sports Physical Therapy of Cape Cod

7) Please check off **ALL** conditions you have been diagnosed with or that may apply:

____Allergies to medications &/or LATEX
____Alcohol / Drug use
____Alzheimer's Disease / Dementia
____Arthritis (osteoarthritis)
____Cancer
____Cardiac / Heart Conditions
____Circulatory / Vascular Problems
____Depression / Anxiety
____Diabetes
____Endocrine Conditions
____Fractures / Broken Bones
____Gastrointestinal / Stomach Problems
____Hearing Problems
____Hepatitis
____High Blood Pressure
____Injuries from Motor Vehicle Accident
____Lung / Respiratory Problems
____Metal Implant
____Neurological Conditions
____Osteoporosis / Osteopenia
____Pacemaker / Defibrillator
____Pregnancy (presently at this time)
____Psychiatric Conditions
____Rheumatoid Arthritis
____Stroke / CVA / TIA
____Tobacco Use
____ Vision / Eye Problems
____HIV /AIDS
Other:________________________________

8) Have you ever received **physical therapy treatment** in the past for this diagnosis/problem? ___ **YES** ___ **NO**

a) If **YES** please list dates: ____

b) **Any other diagnosis**? ____**YES** (if yes please list dates)**:**__________________________

____ **NO**

9) Are you currently receiving **home health care** services consisting of **nursing** and/or **therapy**, and/or home **health aide** services:

_____ **YES:** please describe the type of services you are receiving: ________________________________

_____ **NO**

10) Please list **all medications** you are currently taking including prescription and over-the-counter drugs.

If you already have a written list with you we will gladly make a copy if you prefer.

____
____
____
____
____
____

________________________________ ________________________________

Patient Signature **Reviewed by Provider/ Physical Therapist**

With new healthcare changes, it is important your providers know your medications. Please use this pocket medication record with our compliments. Please feel free to request more copies.

OSPT Orthopedic & Sports Physical Therapy Medication Name	Dose / How much	How often	Purpose / Why I'm using it / Notes	Prescriber/ Doctor

OSPT Orthopedic & Sports Physical Therapy Medication Name	Dose / How Much	How often	Purpose / Why I'm using it / Notes	Prescriber/ Doctor

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