



PATIENT INFORMATION

NAME: Last _____ First _____ M.I. _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: Home _____ Work _____ Cell _____

SEX: M F MARITAL STATUS: (circle) Married Single Widowed

EMPLOYER/OCCUPATION: _____ / _____

DATE OF BIRTH: _____

REFERRING PHYSICIAN: _____

PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT/PHONE: _____ / _____

SPOUSE NAME: _____

SPOUSE EMPLOYER/WORK PHONE: _____ / _____

RESPONSIBLE PARTY INFORMATION

RELATION TO PATIENT: (circle) Self Spouse Parent Other

NAME: Last _____ First _____ M.I. _____

ADDRESS: _____

PHONE: Home _____ Work _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____

Policy Group Name: _____ Policy Group #: _____

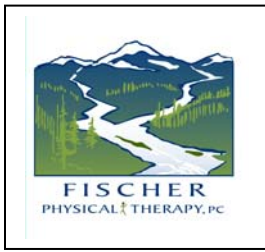
Policy ID #: _____

SECONDARY INSURANCE NAME: _____

Policy Group Name: _____ Policy Group #: _____

Policy ID #: _____

MISCELLANEOUS (OFFICE USE ONLY)Was this injury due to: ___ Motor Vehicle Accident ___ Work Related Injury ___ Accident ___ Other
Date of Injury _____



Patient Intake Questionnaire

Name _____

Date _____ Age _____

SOCIAL HISTORY

1. How did you hear about Fischer Physical Therapy? (circle one) Physician Friend Yellow Pages Newspaper

2. Primary Care Physician: _____ Referring Physician _____

3. Employment/Work

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Working without restrictions | <input type="checkbox"/> Homemaker |
| <input type="checkbox"/> Working with restrictions | <input type="checkbox"/> Student |
| <input type="checkbox"/> Unable to work due to dysfunction | <input type="checkbox"/> Other _____ |

5. Occupation _____

6. Is an attorney involved with this case? ____ No ____ Yes

7. If yes, please provide attorney's name and phone: _____

GENERAL HEALTH STATUS

8. At the present time, would you say that your health is excellent, very good, fair, or poor? _____

9. Please rate your average level of stress (circle) Low Moderate High Very High

10. Have you had any major life changes during the past year? ____ No ____ Yes

If yes, please explain _____

11. Have you sought previous treatment for this condition?

- | | |
|--|--|
| <input type="checkbox"/> No other treatment | <input type="checkbox"/> Psychiatrist/Psychologist |
| <input type="checkbox"/> Massage treatment | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Physical/Occupational therapy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Physical Therapy for other conditions within the past year? | |
- _____

SOCIAL/HEALTH HABITS

12. Currently smoke tobacco No ____ Yes ____ # packs per day ____

13. How many glasses of water do you drink per day? _____

14. If one beer, glass of wine, or cocktail equals one drink, how many drinks do you have on an average week? _____

15. Do you exercise beyond normal daily activities and chores?

No ____

Yes ____ (Include type, days per week, and average time) _____

16. Do you take vitamins daily? No ____ Yes, please list _____

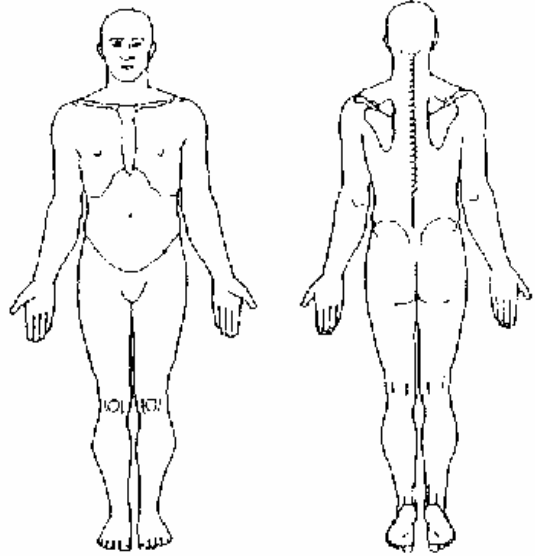
17. Do you take other supplements? No ____ Yes, please list _____

18. What is your pain level *today*?

(low) 1 2 3 4 5 6 7 8 9 10 (high)

19. What is your pain level *on average*?

(low) 1 2 3 4 5 6 7 8 9 10 (high)



20. Please mark the location of your symptoms on the diagram at the right.

MEDICAL/SURGICAL HISTORY

21. Please check if you have ever had the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Ulcers/stomach problems | <input type="checkbox"/> Diabetes or low blood sugar |
| <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Depression or anxiety | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Circulation/Vascular problems | <input type="checkbox"/> Infectious disease (TB, hepatitis) |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Neurological disorder (MS, ALS) | <input type="checkbox"/> High blood pressure | |
| | <input type="checkbox"/> Lung problems | |

22. Within the past year, have you had any of the following symptoms?

- | | | |
|---|--|---|
| <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Pain at night | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Bowel or bladder problems | <input type="checkbox"/> Traumatic Event(s) |
| <input type="checkbox"/> Weakness in arms or legs | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Dizziness or blackouts | 100 |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Weight loss or gain | |

23. Have you ever had surgery? _____ No _____ Yes See attached

If yes, please describe, including dates _____

Additional pages available upon request

24. **For men only:** Have you been diagnosed with prostate disease? _____ No _____ Yes

25. **For women only:** Have you been diagnosed with any pelvic or reproductive problems or disease? _____ No _____ Yes

Are you or could you be pregnant? _____ No _____ Yes

MEDICATIONS

26. Do you take any prescription **or** nonprescription medications?

No _____ Yes _____ See Attached

Prescription: _____

Non-prescription: _____

Additional pages available upon request

CURRENT CONDITION/CHIEF COMPLAINT(S)

27. Please describe the problem(s) for which you seek physical therapy _____

28. What makes the problem(s) better? _____

29.. What makes the problem(s) worse? _____

30. What are your goals for physical therapy? _____

31. Any additional comments _____

We look forward to serving your physical and wellness needs here at Fischer Physical Therapy. Please let us know of any way we can better meet those needs.



CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Fischer Physical Therapy, PC, for the purpose of providing my treatment, obtaining payment for my health care bills, or to conduct health care operations. I understand that my treatment may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or other healthcare operations of the facility. Fischer Physical Therapy is not required to agree to the restrictions that I may request. However, if Fischer Physical Therapy agrees to a restriction that I request, the restriction is binding on Fischer Physical Therapy and my physical therapist.

I have the right to revoke this consent, in writing, at any time, except to the extent that my physical therapist and Fischer Physical Therapy has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physical therapist, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Fischer Physical Therapy's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations. The Notice of Privacy Practices is provided to each new patient and is also available in the waiting room area. This Notice of Privacy Practices also describes my rights and Fischer Physical Therapy's duties with respect to my protected health care information.

Fischer Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

You may be contacted by Fischer Physical Therapy to remind you of appointments and other health services that may be of interest to you.

Signature of Patient _____ Date: _____
(or Personal Representative)

Name of Patient: (please print) _____

For our Medicare Patients:

As of January 1, 2006, Medicare has implemented an outpatient rehabilitation cap of \$1810.00 per beneficiary for the year. This cap covers any and all physical therapy services and speech-language pathology services you receive during the year. Medicare patients are also responsible for a \$135.00 deductible.

Once you have reached the Medicare cap, you have two options:

- 1) receive physical therapy services in an outpatient hospital setting, or
- 2) pay out-of-pocket for our services

I understand the above statement and agree to the consequences of exceeding the yearly Medicare cap.

Initials: _____

New Medicare guidelines also dictate that patients no longer need a physician's referral for physical therapy. This being the case, the policy of Fischer Physical Therapy is as follows:

Generally, you will be seen for up to 30 days. Following the initial evaluation, the physical therapist will write a Medicare Plan of Care indicating the problems, goals, and the frequency of which a patient will be seen and send it to your primary care physician for signature/approval. While waiting for this signature, you may continue physical therapy and Medicare will be responsible for their part of the bill. If the plan of care is not signed, we will discontinue care. Medicare will still be responsible for their part of the bill for all previous visits. By the end of the 30 days, assuming the physician has signed the plan of care, a home exercise program will be developed and the patient will generally be released from further clinical treatments and encouraged to maintain the progress independently with the exercise.

Signature: _____

Date: _____