

# WISDOM PHYSICAL THERAPY

## Patient Intake Forms

### Patient Intake Form & Medical History

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Problem/injury requiring physical therapy: \_\_\_\_\_

Have you ever had treatment for this problem before? YES NO Physical Therapy? YES NO

If yes, when? \_\_\_\_\_ Where? \_\_\_\_\_ Do you smoke? YES NO

List any allergies: \_\_\_\_\_

Please mark appropriate answer if you have had or currently have any of the following. If yes, indicate the date.

	YES	Date	NO
High Blood Pressure	_____	_____	_____
Sensitivity to heat/ice	_____	_____	_____
Heart Attack	_____	_____	_____
Balance Problems	_____	_____	_____
Kidney Problems	_____	_____	_____
Nervous Disorder	_____	_____	_____
Hearing Problems	_____	_____	_____
Vision Problems	_____	_____	_____
Asthma or breathing problem	_____	_____	_____
Arthritis	_____	_____	_____
Hernia	_____	_____	_____

	YES	Date	NO
Seizures	_____	_____	_____
Diabetes	_____	_____	_____
Dizzy Spells	_____	_____	_____
Headaches	_____	_____	_____
Pacemaker	_____	_____	_____
Pregnant	_____	_____	_____
Cancer	_____	_____	_____
Metal Implants	_____	_____	_____
Ulcers or stomach problems	_____	_____	_____
Other medical issue:	_____	_____	_____

Date of injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Describe injury: \_\_\_\_\_

Have you had surgery associated with this problem? YES NO Type of surgery: \_\_\_\_\_

Surgery date: \_\_\_\_/\_\_\_\_/\_\_\_\_

List current medications, include over the counter, herbal, vitamins, etc. \_\_\_\_\_

Have you been hospitalized for this injury? YES NO If yes, when? Hospitalization date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**By signing this form you give permission to WPT to leave voicemail messages on the provided phone numbers. If you do not wish to receive voicemail messages, please sign here:** \_\_\_\_\_

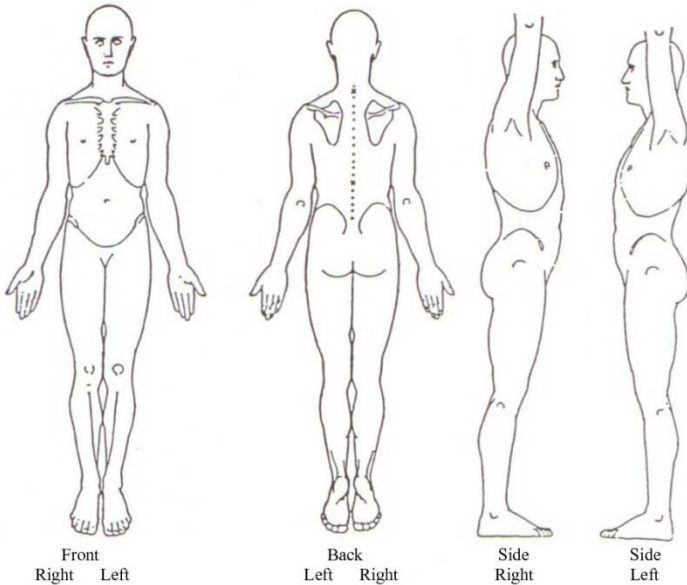
**The intake information and medical history is correct to the best of my knowledge.**

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

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Circle the area of discomfort on the body charts below:



Circle the word that best describes the quality of your discomfort:

- Aching
- Numbness
- Pins & Needles
- Burning
- Stabbing
- Dull
- Other: \_\_\_\_\_

### Pain scale

Pain location: \_\_\_\_\_

At worst 1-----2-----3-----4-----5-----6-----7-----8-----9-----10

At best 1-----2-----3-----4-----5-----6-----7-----8-----9-----10

### Scale Instructions:

**1 - No pain or discomfort.**

**10 - The worst pain you have ever experienced.**

**Aggravating factors: Circle all that cause you pain or discomfort.**

Sitting      Standing      Walking      Stairs-up      Stairs-down      Sit to stand      Bending  
Using restroom      Lying down      Cough/sneeze      Other: \_\_\_\_\_

What alleviates (helps) the pain or discomfort? \_\_\_\_\_

Have you had any Diagnostic testing or Imaging performed? YES NO Type: \_\_\_\_\_

What are your goals for physical therapy? \_\_\_\_\_

**WISDOM PHYSICAL THERAPY**

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**Notice of Information Practices**

This notice describes how medical and other personal information about you may be used and disclosed. It also describes how you can get access to this information. Please review the notice carefully.

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**Patient Information Consent Form**

I understand that Wisdom Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Wisdom Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Wisdom Physical Therapy’s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

**If patient is under 18 years of age:**

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

\_\_\_\_\_  
Parent Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

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### Patient Responsibilities & Cancellation Policy

**1. Check in/Sign-in for each visit:** Please check in with the front office at every visit.

You will need to sign in with the appropriate date and time, also please provide the date of your next doctor's visit. Please let the front office know of any changes in your insurance and or personal information.

\_\_\_\_\_ (initial)

**2. Leave your personal belongings locked in your car:** We provide trays for your car keys and purse, but do not have the space for your other personal belongings. You assume the liability for the safety of your personal items.

\_\_\_\_\_ (initial)

**3. Check out with the front office staff after each visit:** Please check out with the front office after every visit. At your last visit for the week please check with the receptionist and schedule your visits for the following week(s).

\_\_\_\_\_ (initial)

**4. Cell Phones:** Please turn your cell phone **OFF or to VIBRATE** when you enter the building as a courtesy to the therapist and the other patients. *If you need to keep your phone on for urgent calls, we permit the phone to stay on.*

\_\_\_\_\_ (initial)

**5. Pay your co-payment or co-insurance at each visit:** Co-payments are due at the time of your appointment or you can pay at the beginning of the week for all your appointments.

\_\_\_\_\_ (initial)

**6. Give 24-hour notice of cancellation.** No-shows and cancellations without 24-hour notice will result in a **\$25 fee** per no-show.

\_\_\_\_\_ (initial)

**I have read and understand the above policies.**

\_\_\_\_\_

Print Name

\_\_\_\_\_

Signature

Date: \_\_\_/\_\_\_/\_\_\_