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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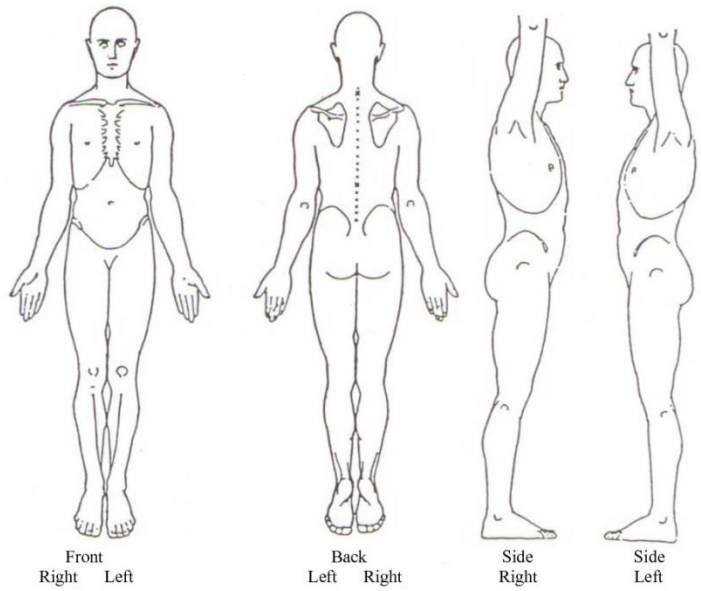
Circle the area of discomfort on the body charts below:



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? _____

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.

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

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

_____ Date: ___/___/____

Signature