RIVER REGION
PHYSICAL THERAPY LLC

NEW PATIENT INTAKE FORM

Last Name:	First Name:
Address:	Apt. or PO Box:
City:	State:
Zip:	Date of Birth:
Home Phone: ( )	E-mail:
Work Phone: ( )	Social Security #:
Cell Phone: ( )	

Emergency Contact

Last Name:	First Name:
Phone: ( )	Relationship:

Employer Information

Employer Name:	Address:
Suite or Office #:	City:
State:	Zip:

Problem/Condition

Description of Problem:	Referred By:
Referral Information:	Date of Onset:

Primary Insurance

Insurance:	Member ID:
Group Number:	Claim Number:
Deductible: Met: ☐ Yes ☐ No	Max Annual Benefit:
Copay:	Co-insurance:
Subscriber's Name:	Subscriber's Date of Birth:
Subscriber's Relationship to Patient:	☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Insurance

Insurance:	Member ID:
Group Number:	Claim Number:
Deductible: Met: ☐ Yes ☐ No	Max Annual Benefit:
Copay:	Co-insurance:
Subscriber's Name:	Subscriber's Date of Birth:
Subscriber's Relationship to Patient:	☐ Self ☐ Spouse ☐ Parent ☐ Other

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DATE: _____

Have you had physical therapy, occupational therapy or chiropractic treatment this year? ☐ Y or ☐ N

If yes, please indicate the type of treatment and the duration of treatment: _____

Have you previously had treatment for this condition? ☐ Y or ☐ N

If yes, for how long: _____

Have ever had surgery? ☐ Y or ☐ N

If yes, please list surgeries: _____

For Medicare Patients Only

Are you currently receiving home care services? ☐ Y or ☐ N

If yes, expected date of completion? _____

Do you have a home care discharge letter? ☐ Y or ☐ N

For Motor Vehicle Accidents Only

If you are receiving care for injuries from a motor vehicle accident, in what state did the accident occur? _____

For Workers' Compensation Cases Only

Name of Adjuster: _____ Phone Number: (_____) _____

CONSENT TO TREATMENT

I consent to receive rehabilitation therapy treatment an any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand the practice of rehabilitation therapist is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or treatment results from rehabilitation therapy.

Signature of Patient or Guardian: _____ Date: _____

FINANCIAL RESPONSIBILITY

I agree to pay my rehabilitation therapy provider ("Provider") all amounts that are due and owing for services rendered by Provider which are not otherwise paid for by Medicare, a third-party insurance plan, a third-party payor, or other payor source on my behalf. It is my responsibility to be aware of my insurance benefits and any potential patient payment responsibilities. If my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due and owing for services render by Provider including, without limitation reasonable attorney's fees.

Signature of Patient or Guardian: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge receipt of a copy Provider's Notice of Privacy Practices.
(Please Print)

Signature of Patient or Guardian: _____ Date: _____

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NAME: _____ DATE: _____

Medical History

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

- ☐ No Diseases or Conditions
- ☐ Cancer _____
- ☐ Depression
- ☐ Diabetes
- ☐ Circulation/Vascular Problems
- ☐ Stroke
- ☐ Heart Problems
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Headaches/Migraines
- ☐ Hepatitis
- ☐ HIV or AIDS
- ☐ Fibromyalgia

Surgical History

Please list any type and dates of surgeries below:

- ☐ No Surgeries
- ☐ Shoulder Surgery _____
- ☐ Knee Surgery _____
- ☐ ACL Reconstruction _____
- ☐ Back Surgery _____
- ☐ Joint Replacement _____
- ☐ Ankle/Foot Surgery _____
- ☐ Hip Surgery _____
- ☐ Achilles Tendon Repair _____
- ☐ Heart Surgery _____
- ☐ Elbow Surgery _____
- ☐ Neck Surgery _____

Other: _____

_____

Are you currently pregnant? ☐Y or ☐N

Please describe your current pain:

Location of pain: _____

☐ None ☐ Mild ☐ Severe

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NAME: _____ DATE: _____

Please list activities that aggravate your symptoms: _____

_____

_____

Please list things that relieve your symptoms (medications, ice, changing positions, etc.)

_____

_____

_____

Occupation: _____

What activities are you currently limited with that you would like to return to after completing physical therapy? _____

_____

_____

Have you had physical therapy this year? ☐ Y or ☐ N

Are you currently receiving any home health services? ☐ Y or ☐ N

Please list current medications and dosages: _____

_____

_____

_____