



Physical Therapy Intake Form

Date: _____

Name: _____

Home Address: _____

Home/Mobile Phone: (____) _____ Work Phone: (____) _____

Please circle preferred # to be used above

Birthdate: _____ Age: _____ Sex: M / F Student: No / Full-time / Part-time

Email Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (____) _____

Employment (circle): Full / Part / Parenting / Homemaking / Not Working / Retired

Employer: _____

Employer Address: _____

Referring Physician: _____ Phone: (____) _____

Physician Practice Name / Address: _____

Whom may we thank for your referral? _____

Injury / Symptom Onset Date: _____

Area(s) Being Treated: _____

Primary Insurance: _____

Insurance Member #: _____ Group #: _____

Insured's Name: _____

Insured's Date of Birth: _____

~~~~Please fill out at least everything above. Below may or may not apply. ~~~~

Secondary Insurance: \_\_\_\_\_

Insurance Member #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Social Sec #: \_\_\_\_\_

Attorney Involvement: Yes / No Attorney: if applicable \_\_\_\_\_

Attorney Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Attorney Address: \_\_\_\_\_



# Medical History Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Injury / Condition: \_\_\_\_\_

Date of Injury / Onset: \_\_\_\_\_ How did it happen? \_\_\_\_\_

Type of Symptom: Sharp / Burning / Aching / Tingling / Numbness / Other: \_\_\_\_\_

Rate your pain on a scale of 1 to 10 (1=almost nonexistent, 10=most severe imaginable): \_\_\_min \_\_\_max

What other injuries or medical conditions have you had before this or including this, and when did they start? \_\_\_\_\_

Your current weight: \_\_\_\_\_ Height: \_\_\_\_\_

Type of Surgery & Date: \_\_\_\_\_

Next Physician's Appointment (date and purpose): \_\_\_\_\_

Previous Treatment for this: \_\_\_\_\_

Have you ever had any imaging or other tests performed? When? \_\_\_\_\_

X-Ray  MRI  CT Scan  Doppler  Ultrasound  Bloodwork  Other \_\_\_\_\_

Have you recently noted any of the following?

Weight Loss/Gain  Weakness  Pregnancy/IUD  Pain at Night  Nausea/Vomiting  Fatigue

Fever/Chills/Sweats  Cramps when walking  Headaches  Fatigue  Numbness/Tingling

Change in Vision/Hearing  Insomnia

Do you have now, or have you ever had any of the following?

Surgeries  Sprains/Strains  Heart Problems  Circulation Problems/Clots  Easy Bruising/Bleeding

Indigestion/Heartburn  Loss of Consciousness  Diabetes  Cancer  Asthma/Breathing Problems

Leg/Ankle Swelling  Fainting  Fractures  Blood Pressure Problems  Motor Vehicle Accident

Lung Disease  Urinary Problems/Infections  Allergies/Skin Sensitivity  Pregnancy (# of: \_\_\_\_\_)

Childbirth (# of \_\_\_\_\_)  Depression  Irritability / Anxiety  Mental Health Conditions  Autoimmune

Testing / Diagnosis  General Joint Pain  Problems with Memory  Incontinence of bowel and/or bladder

Explain and give approximate dates for any items indicated above: \_\_\_\_\_

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Please give approximate dates for major life events: (examples: career change / job loss, marriage, divorce, death of loved one, accident (car, sports,...), change of residence, etc.)

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How are your relationships with your: \_\_\_friend(s)/peers? \_\_\_parent(s)? \_\_\_partner? \_\_\_boss?  
\_\_\_teacher(s)? \_\_\_coworker(s)? \_\_\_sibling(s)? \_\_\_child(ren)? *In the blank before each, mark G for Good, T for Troubled, U for Unsure, or N/A for Not Applicable*

Explain your sleep patterns: What time do you go to bed?\_\_\_\_\_ What time do you wake?\_\_\_\_\_  
How often do you wake in the night (or day if you sleep in the day)? \_\_\_\_\_ What wakes you? \_\_\_\_\_  
\_\_\_\_\_ How easily do you fall asleep at first? \_\_\_\_\_

How easily do you fall back asleep once having wakened?\_\_\_\_\_

What do you eat for breakfast? \_\_\_\_\_ Snacks? \_\_\_\_\_  
\_\_\_\_\_ Lunch? \_\_\_\_\_

Dinner?\_\_\_\_\_ What drinks (coffee, water, juice, soda, etc.)  
do you have throughout the day?\_\_\_\_\_ Do you smoke? \_\_\_\_\_ (how much if yes)

Do you drink alcohol?\_\_\_ if yes, how much per day/week?\_\_\_\_\_ Use other drugs? \_\_\_\_\_

Exercise/movement: What kind of exercise or movement do you get in a day? \_\_\_\_\_

How much exercise do you get in a week? \_\_\_\_\_ What do you do for exercise or  
movement?\_\_\_\_\_

Would you like to get more or less exercise than you currently do? \_\_\_\_\_

What do you do to relax? \_\_\_\_\_

What is stressful to you? \_\_\_\_\_

What is / are your favorite thing(s) to do? \_\_\_\_\_

Are you currently taking any medications? Yes / No Herbal/Other Remedies: Yes / No

Name/Type(s) of Medication or other remedies: **include dosage** \_\_\_\_\_

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What positive outcomes do you hope to get out of your treatment? \_\_\_\_\_

\_\_\_\_\_ What are your physical/fitness/other wellness goals?\_\_\_\_\_

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What would you like to ask your physical therapist? \_\_\_\_\_

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What is your favorite type of music or who are your favorite artists/bands/composers?\_\_\_\_\_

\*\*\* PLEASE READ AND SIGN BELOW \*\*\*



## Consent Form

Physical Therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color, race, creed, national origin, or disability. The purpose of physical therapy is to treat disease, injury and disability by evaluation, examination, testing and use of rehabilitative procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving his or her maximum potential within their capabilities: and to accelerate convalescence and reduce the length of the functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them. You are expected to cooperate fully with the evaluation and treatment program. Because of the nature of services provided, you might be asked to change into other clothing or doff certain articles of clothing in order to reveal the area being treated. If this is necessary, your privacy, modesty and dignity will be considered at all times. Should you feel uncomfortable or should this conflict with religious beliefs, you may refuse. There are certain inherent risks with physical therapy treatments as you will be asked to exert effort and perform activities with increasing degrees of difficulty which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. You will be able to stop treatment if you feel any discomfort or pain. Your physical therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure which you do not wish to perform. Because of the nature of the procedures performed with the clinical setting, your communication with family and friends during time of treatment may be restricted to ensure you receive the maximum therapeutic value from treatment.

Based on the above information, I \_\_\_\_\_ ,  
agree to cooperate fully, to participate in all physical therapy procedures, and to comply with the plan of care as it is established. I have read the consent form and authorize release of medical information to appropriate third parties. I authorize Terra Physical Therapy to furnish information to insurance carriers concerning this treatment, and I assign payment for services rendered.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\*\*\* PLEASE READ AND SIGN BELOW \*\*\*



## Mission

At Terra Physical Therapy, the goal is to give each client the tools he or she can use to bring about a sense of health, comfort, and wellness. This could be achieved by any number of means, including manual modalities, rehabilitative exercise, and therapeutic activity modifications. Care will be taken that this is in a safe environment with mindfulness of the whole of each individual and his or her social, emotional, physical, and spiritual being.

## Cancellation / Change Policies

If you must cancel an appointment less than 24 hours prior to your scheduled time, you are subject to a \$65 late cancellation fee. Cancellation fees may not be applied toward your deductible or billed to your insurance company.

## Understanding the Billing Process

It would be in your good interest to know your insurance plan's coverage provisions and requirements. Be sure to read your benefits handbook and question your insurance company on any areas that are unclear.

If using private insurance, you will be responsible for making your co-payment, coinsurance payment, or payment toward your deductible at the time of each visit, until or unless the deductible and/or out-of-pocket maximum amounts have been met.

Price quotes for services are estimates only. Your final bill will reflect your total charges, monies paid and any outstanding balances due.

If you wish to pay for physical therapy services directly without using private insurance, payment must be made at the time services are rendered.

If you are unable to pay for your portion of your bill in full, please communicate your needs to arrange mutually acceptable payment options.

*By signing below, you authorize Terra Physical Therapy to apply for benefits on your behalf for services rendered. If using private insurance, you request payment from your insurance company be made directly to Terra Physical Therapy. You certify that the information you have reported with regard to your insurance coverage is correct, and you further authorize the release of any necessary information, including medical information for this or any related claims. You permit a copy of this authorization to be used in place of the original. This authorization may be revoked by you at any time in writing. You understand that nothing herein relieves you of the primary responsibility and obligation to pay for medical services provided.*

## Feedback

Before, during, and after your episode of care, please take any opportunity to communicate how your experience has been and how Terra PT can best be of service to you.

## Notice of Receipt

Your signature below is acknowledgment of your receipt and understanding of the aforementioned policies and of the HIPPA guidelines provided under separate cover.

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Signature

Date