Patient Intake Information

Demographic Information

Last Name	First Name		M.I.
D.O.B.	Last 4 SS #	Sex M F	Preferred/Nickname
Address	City	State	ZIP
Home Phone	Cell Phone	Email	

Emergency Contact Info

Name	Phone	Relationship

Employer Information (Work Comp Only)

Employer	☐ Full Time	☐ Part Time	☐ Retired	☐ Disabled ☐ Unemployed
Address	City	State	Zip	
Phone	Occupation			

Referring Physician Information

Physician Name	Phone #	RX Date

Additional Information

Injury Onset Date	Surgery ☐ Yes ☐ No	Surgery Date	Body Part
Work Related ☐ Yes ☐ No	Accident Related ☐ Yes ☐ No	Attorney Involved?	
Auto Related ☐ Yes ☐ No	Attorney/Case worker contact information		
Prior Therapy this year? PT/OT/ST/Chiropractic ☐ Yes ☐ No	How did you hear about us?		

Insurance Information

Primary Insurance			Secondary Insurance		
Insurance Plan			Insurance Plan		
Member ID#			Member ID#		
Group #	Phone#		Group #	Phone#	
Policy Holder (If NO, see below) ☐ Yes ☐ No			Policy Holder (If NO, see below) ☐ Yes ☐ No		
Policy Holder Name	D.O.B.	Relationship	Policy Holder Name	D.O.B.	Relationship

What Problem(s) are you being seen for today? Describe type and location of symptoms

_____

_____

_____

What date (roughly) did your current problem start? _____

Treatment Received so far, for this problem: Chiropractic Acupuncture Injections PT/OT Other

If Other, please specify: _____

Special Testing Done: X-Ray Bone Scan MRI CT Scan

My Symptoms currently: Come and Go Are Constant Constant, but change with activity (Please specify)

_____

What makes your symptoms better? _____

What makes your symptoms Worse? _____

What are your goals for physical therapy? _____

_____

Surgical History

Please list any surgeries/Injuries (Falls, Implants, Pacemakers, Knee/Hip replacements) with dates if possible

_____

_____

_____

Any falls within the past year? **Did the fall result in injury?** **Yes** **No**

Other Health Information

Please list any allergies (Latex, Adhesives, etc.) _____

Are you pregnant? Yes No If yes, how many weeks? _____

Do you live alone? Yes No If no, who lives with you? _____

Where do you live? My Home with Family Condo/Apt Group Home Nursing Home

Patient Signature: _____ Date:_____

I certify that the above information is true and accurate to my best knowledge on the date this form was signed.

TOTAL BODY REHAB

Patient Name: _____

Medical History

Race/Ethnicity (please select one)

Caucasian **African American** **Hispanic/Latino** **Alaskan/Inuit** **Asian** **Other** **Decline**

Do you currently have or have you had any of the following:			
Smoking (includes smokeless tobacco)	**Y N**	Infectious Diseases	**Y N**
Diabetes	**Y N**	Neurologic Condition (MS/Parkinson's)	**Y N**
Heart Condition	**Y N**	Pediatric Developmental Condition	**Y N**
High Blood Pressure	**Y N**	Skin Disease	**Y N**
Chest Pain	**Y N**	Spinal Cord Injury	**Y N**
Stroke	**Y N**	Degenerative Joint Disease	**Y N**
Kidney Condition	**Y N**	Difficulty Balancing	**Y N**
Breathing Difficulties	**Y N**	Weakness/Fatigue	**Y N**
Asthma	**Y N**	Arthritis	**Y N**
Circulation/Vascular Problems	**Y N**	Osteoporosis	**Y N**
Peripheral Neuropathy	**Y N**	Psychological Conditions	**Y N**
Unexplained Weight Loss	**Y N**	Seizures	**Y N**
Changes in Appetite	**Y N**	Fractures	**Y N**
Double Vision	**Y N**	Infection	**Y N**
Dizziness/Faintness	**Y N**	Fibromyalgia	**Y N**
Ringing in Ears	**Y N**	Headaches	**Y N**
Head Injury	**Y N**	Other- Please specify	
Other- Please specify			

Do you have a Primary Care Physician (PCP)? **Yes** **No**

Primary Care Physician: _____

Address: _____ Phone: _____

Patient Signature: _____ **Date:** _____

I certify that the above information is true and accurate to my best knowledge on the date this form was signed.

TOTAL BODY REHAB

Medication List **Name:** _____

Please list ALL medications (Including prescription, over the counter, vitamins, dietary or nutritional supplements) which you take routinely or on an as needed basis			
Medication	**Dosage**	**Frequency**	**Route of administration**

Allergies to medications? If yes, please list medications and reactions.

_____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ **Date:**_____

I certify that the above information is true and accurate to my best knowledge on the date this form was signed.

TOTAL BODY REHAB

Consent Form

Name: _____

Consent to Treat I consent to rehabilitation and related services at Total Body Rehab Services. In doing so, I understand, acknowledge and affirm that such services may involve bodily contact, touch and/or other direct contact of a sensitive nature	Initial
Treatment of Minors I, as a parent or guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during such treatment and waive any claim I may have resulting in failure to do so.	Initial
Waiver and Release I hereby release, discharge and acquit: Total Body Rehab Services, its agents, representatives, affiliates, employees, or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency or medical services including, but not limited to Ambulance Services, Emergency Medical Technician, Physical or Urgent Care Services.	Initial
Liability I know and agree that Total Body Rehab Services is not responsible for loss or damage to personal valuables	Initial
Authorization of Payment I hereby assign all benefits directly to Total Body Rehab Services. I also authorize the release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice of Privacy Practices.	Initial
Financial Policy I understand fully that, in the event my insurance company or financially responsible party does not pay for services I receive, I will be financially responsible for payment. To assist in establishing your account: -Supply all necessary information for accurate claim, including insurance card, driver's license, employer information and demographic information -Satisfy all insurance co-payments, co-insurances, deductibles and all non-covered services on the day services are rendered. -Provide your insurance company and us with any additional information requested to process claims filed on your behalf. ***In the event that this account is referred to a collection agency, (Buyer, Client, Etc.) agrees to pay any collection fees incurred by Total Body Rehab Services LLC in addition but not limited to any attorney's fees or costs of collections.*	Initial
Communications Consent -I agree to receive email communication regarding appointment updates and marketing communications from Total Body Rehab Services at the following email address on file	Initial
-I agree to receive Text Message communication regarding appointment updates and marketing communications from Total Body Rehab Services at my phone number.	Initial
-I consent Total Body Rehab Services to leave a message on my voice mail/answering machine regarding appointment updates and marketing communications at my phone number.	Initial
-I give permission to the person (s) listed below to receive detailed information regarding my appointments, medical care, billing and payment information. I understand that this **DOES NOT** authorize the disclosure of my written health information.	Initial

I give permission to the person (s) listed below to receive detailed information regarding my appointments, medical care, billing and payment information. I understand that this **DOES NOT** authorize the disclosure of my written health information. I understand that there is some level of privacy risk associated with each of these forms of communication.

_____ Relationship: _____

_____ Relationship: _____

Patient/Guardian Signature: _____ **Date:** _____

I certify that the above information is true and accurate to my best knowledge on the date this form was signed and that my initials serve as a signature for the purposes of this form.