PATIENT INFORMATION

First Name: ________________________________ **MI:**_____ **Last Name:** _________________________________

Nick Name: _____________ **SSN:** __ __ __ - __ __ - __ __ __ __ **Gender:** M /F **D.O.B.:** __ __ - __ __ - __ __ __ __

Marital Status: (S/M/D/W) **Patient Status: (NA / Employed / Full-time Student / Part-time Student)**

Address: ____ **City:** ____

State: __________ **Zip Code:** _________________ **Email:** ____

Home #: (_______)_________________ **Cell #:** (_______)_________________ **Work #:** (_______)________________

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Appointment Reminder: □ Email □ Text **Preferred method of other communication:** Phone / Email / Text / Mail

Summit Physical Therapy may leave messages on my phone? □Yes □No

How were you referred to Summit PT: Summit Website / Physician / Insurance / Friend / Former Patient

- -

Emergency Contact & Relationship: __________________________________ **Phone #:** (____) _________________

This emergency contact is permitted to discuss the medical conditions of the patient. □Yes □No

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Family/Referring Physician: ____________________________________ **Phone #:** (_______)____________________

Employer Name: ____ **Phone #:** (_______)_________________________

Name of Insurance: ____

Subscriber's Name/D.O.B.: ____

Subscriber's Employer: ____

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BILLING CONSENT

I hereby authorize **SUMMIT PHYSICAL THERAPY** to release any information concerning my case to the appropriate individuals or insurance companies. I hereby accept full responsibility for any amount not covered by my insurance. I authorize payment of medical benefits to **SUMMIT PHYSICAL THERAPY**

TREATMENT CONSENT AUTHORIZATION: I am fully aware of my medical diagnosis and prognosis and consent to allow **SUMMIT PHYSICAL THERAPY** to provide treatment for my condition.

SIGNATURE: ________________________________ **PRINT NAME:**_______________________**DATE:** _____________

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Today's Date: __________ Name: _________________________ Height: ________ Weight: ________

Medical History

Do you now, or have you in the past had any of the following conditions? ___________

Allergies	□Yes □No	Diabetes	□Yes □No	Metal Implants	□Yes □No
Anemia	□Yes □No	Dizzy Spells	□Yes □No	MRSA	□Yes □No
Anxiety	□Yes □No	Emphysema/Bronchitis	□Yes □No	Multiple Sclerosis	□Yes □No
Arthritis	□Yes □No	Fibromyalgia	□Yes □No	Muscular Disease	□Yes □No
Asthma	□Yes □No	Fractures	□Yes □No	Osteoporosis	□Yes □No
Autoimmune Disorder	□Yes □No	Gallbladder Problems	□Yes □No	Parkinson's	□Yes □No
Cancer	□Yes □No	Headaches	□Yes □No	Rheumatoid Arthritis	□Yes □No
Cardiac Conditions	□Yes □No	Hearing Impairments	□Yes □No	Seizures	□Yes □No
Cardiac Pacemaker	□Yes □No	Hepatitis	□Yes □No	Smoking	□Yes □No
Chemical Dependency	□Yes □No	High Cholesterol	□Yes □No	Speech Problems	□Yes □No
Circulation Problems	□Yes □No	High/Low Blood Pressure	□Yes □No	Strokes	□Yes □No
COVID-19	□Yes □No	HIV/AIDS	□Yes □No	Thyroid Disease	□Yes □No
Currently Pregnant	□Yes □No	Incontinence	□Yes □No	Tuberculosis	□Yes □No
Depression	□Yes □No	Kidney Problems	□Yes □No	Vision Problems	□Yes □No

If you answered yes to any medical condition, please explain. ____

____

Do you have any other medical conditions or medical precautions not listed above? _________________________

____

FALL HISTORY

Are you at risk for a fall? □Yes □No **How many falls have you had in the past year?** None / One / Two

SURGICAL HISTORY

(Have you had any surgery on any part of your body? If yes please answer the following, if no please indicate none.)

Body Region: _________________________ Surgery Type: ______________________________ Date: ____________

Body Region: _________________________ Surgery Type: ______________________________ Date: ____________

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Body Region: _________________________ Surgery Type: ______________________________ Date: ____________

CURRENT MEDICATIONS:

(What medication(s) are you currently taking? Please also include the dosage. If you are not taking any medication please check the box below)

Drug: ___________________ Dosage: _____________ Frequency: _______________ Reason Taking: ______________

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Drug: ___________________ Dosage: _____________ Frequency:_______________ Reason Taking: ______________

□ **Currently not taking any medications** List any medication allergies_____________________________

____

Summit Physical Therapy-Patient Intake

TESTING- Have you had any of the following medical testing in the last 12 months?

X-Rays: □Yes □No **MRI:** □Yes □No **CAT Scan:** □Yes □No **EMG/NCV:** □Yes □No **Bone Scan:** □Yes □No

______________	______________	______________	______________	______________
(Date)	*(Date)*	*(Date)*	*(Date)*	*(Date)*

Approximate date of injury for which you are seeking treatment:____

Why are you seeking physical therapy: ____

____

____

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Are you receiving home care at the current time? □Yes □No

If yes, what is the home care company name? ____

If no, when were you discharged? ____

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PRIOR PHYSICAL THERAPY

Have you received any physical therapy or chiropractic care in the last 12 months? □Yes □No

If yes, what were you treated for? ____

Was it due to an injury? □Yes □No **Was it a gradual onset?** □Yes □No

Is the problem work-related? □Yes □No **Were you involved in a motor vehicle accident?** □Yes □No

Is litigation (lawsuit) involved? □Yes □No **If yes, who is your attorney?** ___________________________________

Have you ever had any prior injuries involving the same area? □Yes □No

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I, the undersigned, state I have answered the questionnaire to the best of my knowledge.

Signature ____ Date ___________________________________

Summit Physical Therapy-Patient Intake

PAIN LOCATION

On the diagram below, use the **SYMBOLS** to indicate the type of pain you're feeling and where. Also write down your pain level using the **PAIN SCALE**.

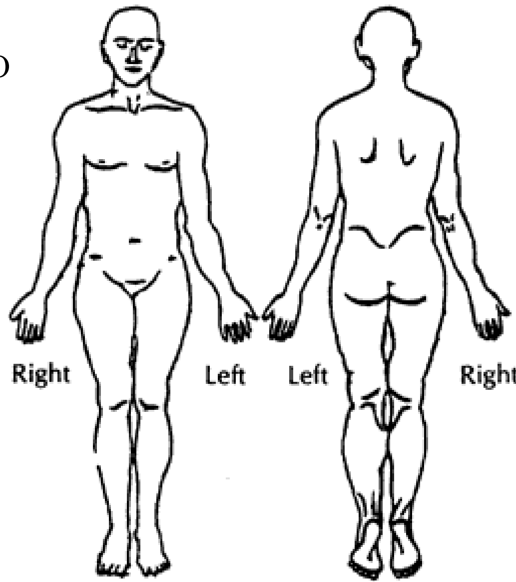
SYMBOLS

Pins and Needles = OOOOOO

Stabbing = /////////

Burning = XXXXXXX

Deep Ache = ZZZZZZZZ



PAIN SCALE

0 = No Pain through **10 = Extreme Pain**

Current pain level now: _______________

Worst pain level in last 24 hours: ______

Best Pain level in last 24 hours: ________

Place a √ in the box(es) that best describe your pain.

	Constant		Increasing		Night Pain		Dull/achy pain
	Intermittent		Decreasing		Stiffness		Pain upon walking
	Occasional		Static		Sharp pain		After standing or walking too long

My Pain is aggravated by: ____

My Pain is eased by: ____

I, the undersigned, state I have answered the questionnaire to the best of my knowledge.

Signature ______________________________________ Date ____________________________

Summit Physical Therapy-Patient Intake

Acknowledgement of Receipt of Notice of Privacy Practices

First Name: ________________________ MI: _____ Last Name: _____________________ DOB: ________

In general, any information you receive about your health care, or payment for the care, is considered confidential and protected by our practice. We may need to use your protected health information to carry out treatment, payment health care operations and/or other purposes. Our notice of privacy practices provides a more complete description of permitted uses and disclosures.

I acknowledge that I have received a copy of the Notice of Privacy Practices.

____ ________________________

Please print patient's full name Date

____ ________________________

Signature of patient or patient representative(if under 18) Relation

Consent to Treatment and Authorization to Bill for Services

1. I am consenting to examination and treatment by physical therapists employed by Summit Physical Therapy. I understand I will not be involved in research or experimental procedures without my knowledge or consent.

2. I am responsible for paying for all services provided to me, which may include collection fees, and agree any insurance benefits for my account will be paid directly to Summit Physical Therapy. I authorize Summit Physical Therapy to submit insurance claims on my behalf. I certify all information given by me in applying for payment by any third party is true and accurate.

3. I authorize release of my medical bills to the person whose medical insurance is paying all or part of my account.

4. I authorize Summit Physical Therapy to submit Medicare claims on my behalf and request payment of authorized Medicare benefits be made directly to Summit Physical Therapy for any services provided. Additionally, I authorize release of any medical information regarding my care in order to determine potential payable services.

I authorize Summit Physical Therapy to disclose my personal health information to the following individual(s) who are involved in my care:

Printed Name of Individual	Relationship to Patient	Telephone Number
Printed Name of Individual	Relationship to Patient	Telephone Number

I have been given the opportunity to ask questions about this document. By signing below, I declare that I understand the above information:

____ ________________________

Signature of Patient or Representative Date