NEW PATIENT INTAKE AND CONSENT FORM Date_____

First Name:_____ MI:_____ Date of Injury:_____
Last Name:_____ Date of Birth:_____
Address:_____ Sex: ☐ Male ☐ Female
City:_____ State:_____ Zip:_____ Home Phone:_____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Cell Phone:_____
SS#_____ Work Phone:_____
E-Mail:_____ Do you want e-mail reminders for appts? ☐ Yes ☐ No

Responsible Party:_____ Employer:_____
Address:_____ Address:_____
City:_____ State:_____ Zip:_____ City:_____ State:_____ Zip:_____
Relationship to Party:_____ Phone:_____ DOB of Responsible Party:_____
Primary Insurance:_____ Secondary Insurance:_____

Member ID:_____ Member ID:_____
Group #:_____ Group #:_____

How did you hear about us? Magazine_____ Seminar_____ Newspaper_____ T.V._____ Referral_____

Emergency Contact:_____ Phone Number:_____ Relation to Patient_____

Durable Power Attorney:_____ Phone Number:_____ Relation to Patient_____

Are you receiving or have you recently received home health services? Yes ☐ No ☐
Are receiving or have your recently received other therapy services? Yes ☐ No ☐

Consent to Treatment: Patient authorizes Dr. and/or associates and staff (1) to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis, (2) to render medical services and perform all recommended treatment mutually agreed upon. I also agree to the use of appropriate medication and therapy indicated for such treatment and I understand that using anesthetic agents embodies a certain risk, (3) I understand that all responsibility for payment for medical services provided in this office for myself or my dependents is mine, (4) I understand that it is my responsibility to advise your office of any changes in the information contained in this form. _____**(Initial)**

Consent to pull medicine list from online portal: I give Freedom Healthcare consent to pull my list medicine from an online portal to verify what medicines I am taking. _____(Initial)

Consent to Treat - Physical Therapy: I consent to rehabilitation and related services at Freedom Healthcare. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____**(Initial)**

Liability: I know and agree that Facility is not responsible for loss or damage to personal valuables. _____**(Initial)**

Waiver and Release: I hereby release, discharge and acquit Facility , it's agents, representatives, affiliates, employees, or assigns, of and from any 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 and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.
_____**(Initial)**

Authorization of Payment: I hereby assign all benefits directly to Facility and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment._____**(Initial)**

Notice of Privacy: I acknowledge receipt of Notice of Privacy Practices. _____**(Initial)**

I certify that all of the information provided herein is true and correct.

Patient Signature:_____ Witness Signature:_____

Patient Assessment

Patient Name:_____

Date of Birth:_____ **Patient ID#:**_____

Primary Care Doctor (Name and Address) _____

REVIEW OF SYSTEMS: CIRCLE ALL THAT APPLY *within the last 30 days*

Systemic Symptoms:			**Respiratory:**			**Musculoskeletal:**			**Psychiatric:**		
Feeling fine	**Yes**	**No**	Difficulty breathing	**Yes**	**No**	Neck Pain	**Yes**	**No**	Difficulty Concentrating	**Yes**	**No**
Feeling fatigue	**Yes**	**No**	Cough	**Yes**	**No**	Shoulder pain	**Yes**	**No**	Anxiety	**Yes**	**No**
Fever	**Yes**	**No**	Coughing up blood	**Yes**	**No**	Upper back pain	**Yes**	**No**	Insomnia	**Yes**	**No**
Chills	**Yes**	**No**	Wheezing	**Yes**	**No**	Mid-back pain	**Yes**	**No**	Depression	**Yes**	**No**
Recent weight loss ____			**Cardiovascular:**			Lower back pain	**Yes**	**No**	**Dermatological:**		
Recent weight gain____			Chest pain	**Yes**	**No**	Hip pain	**Yes**	**No**	Redness of skin	**Yes**	**No**
Head:			Rapid heartbeat	**Yes**	**No**	Knee pain	**Yes**	**No**	Skin lesion	**Yes**	**No**
Headaches	**Yes**	**No**	Fainting	**Yes**	**No**	**Neurological:**			Rash	**Yes**	**No**
Eyes:			Edema	**Yes**	**No**	Dizziness	**Yes**	**No**			
Blurry vision	**Yes**	**No**	**Gastrointestinal:**			Memory loss	**Yes**	**No**			
Eye pain	**Yes**	**No**	Difficulty swallowing	**Yes**	**No**	Tingling	**Yes**	**No**			
Wearing glasses	**Yes**	**No**	Heartburn	**Yes**	**No**	Numbness	**Yes**	**No**			
Wearing contacts	**Yes**	**No**	Nausea	**Yes**	**No**	Seizure	**Yes**	**No**			
Ears:			Vomiting	**Yes**	**No**	Mental status change	**Yes**	**No**			
Hearing Loss	**Yes**	**No**	Abdominal Pain	**Yes**	**No**	**Endocrine:**					
earache	**Yes**	**No**	Diarrhea	**Yes**	**No**	Increased Thirst	**Yes**	**No**			
Drainage from Ears	**Yes**	**No**	Constipation	**Yes**	**No**	Increased Urination	**Yes**	**No**			
Ringing in ears	**Yes**	**No**	Liver disease	**Yes**	**No**	Too hot	**Yes**	**No**			
Hearing Aid	**Yes**	**No**	Renal disorder	**Yes**	**No**	Too cold	**Yes**	**No**			
Nose:			**Genitourinary:**			Low Thyroid	**Yes**	**No**			
Nasal discharge	**Yes**	**No**	Blood in urine	**Yes**	**No**	High Thyroid	**Yes**	**No**			
Nosebleeds	**Yes**	**No**	Urinate a lot	**Yes**	**No**	Diabetic	**Yes**	**No**			
Throat:			Urinary urgency	**Yes**	**No**	**Hematologic:**					
Swollen glands in neck	**Yes**	**No**	Pain during urination	**Yes**	**No**	Bleed easy	**Yes**	**No**			
Hoarseness	**Yes**	**No**	Bladder incontinence	**Yes**	**No**	Bruise easy	**Yes**	**No**			
Sore throat	**Yes**	**No**				Swollen lymph nodes	**Yes**	**No**			
Dentures	**Yes**	**No**				Anemia	**Yes**	**No**			

Patient Signature_____ **Date**_____

Patient: _____ **ID#**_____ **Date:** _____

FAMILY HISTORY:

Please indicate with a check (√) family members who have had any of the following conditions:

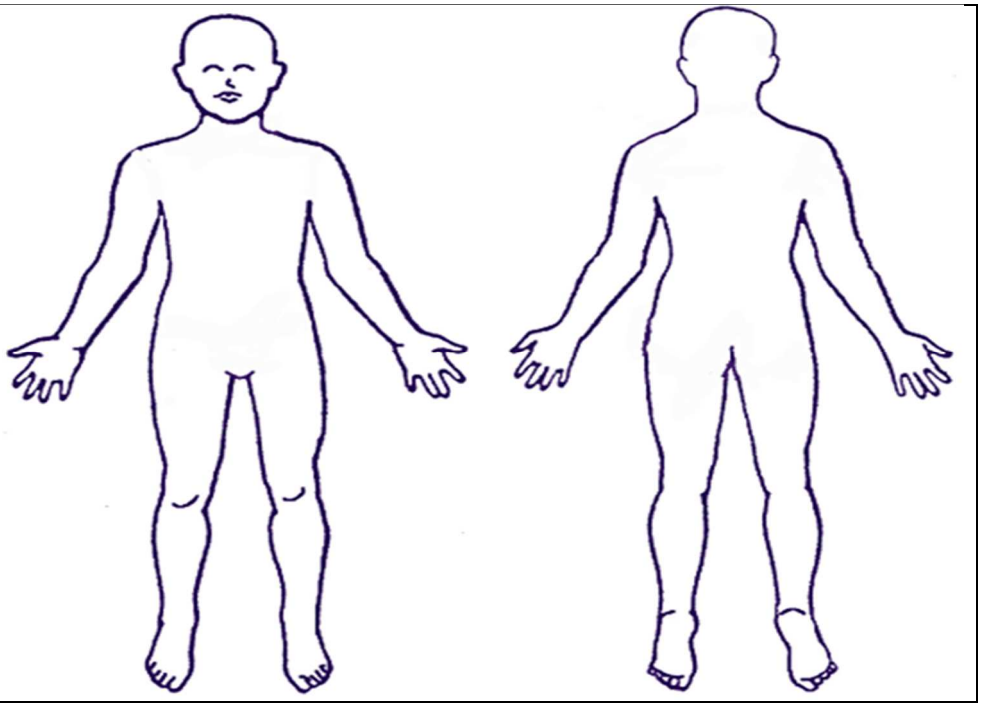
Medical Condition	**Dad**	**Mom**	**Brother**	**Sister**	**Daughter**	**Son**	**Other**
Alive and Healthy							
Deceased							
Alcoholism							
Anemia							
Anesthesia Problem							
Allergies (hay fever/allergic rhinitis)							
Asthma							
Bleeding Problem							
Cancer, Breast							
Cancer, Colon							
Cancer, Melanoma							
Cancer, Skin (other than melanoma)							
Cancer, Ovarian							
Cancer, Prostate							
Cancer, Other							
Depression							
Diabetes, Type 1 (child onset)							
Diabetes, Type 2 (adult onset)							
Eczema							
Epilepsy (seizures)							
Genetic Diseases							
Glaucoma							
Hearing Disorders							
Heart Attack (coronary artery disease)							
High Blood Pressure (hypertension)							
High Cholesterol (hyperlipidemia)							
Kidney Disease							
Migraine Headaches							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke							
Thyroid disorders							
Tuberculosis							
Other:							

Patient Signature_____ **Date**_____

Rehabilitation Screening/Confidential Medical History

Patient's Name:_____ **ID:**_____ **Date:**_____

1. Reason for this visit?_____
2. Date of injury or when problem began:_____
   a. Date it worsened (if applicable):_____
3. How did your current problem begin?_____lifting _____twisting _____falling
   ____ motor vehicle accident ___unknown ____ bending other:_____
4. Were you hospitalized for this problem?___yes ___no If yes give dates:_____
5. Did you have any diagnostic test (x-rays, MRI, and CT scan)? _____
   a. Results?_____
6. Have you experienced similar symptoms before __yes __no
   a. Indicate on the body diagrams where your symptoms occur:
      Check any that you are experiencing:

☐ Aching ☐ Stabbing ☐ Numbness ☐ Burning ☐ Stiffness ☐ Popping ☐ Gives out ☐ Swells ☐ Limits range of motion ☐ Movement increases pain ☐ Bearing weight increases pain	

   b. Rate your pain using the following scale, with 0 being no pain and 10 being very severe pain:
      During rest: 0 1 2 3 4 5 6 7 8 9 10
      During activity: 0 1 2 3 4 5 6 7 8 9 10

Aggravate/Increase Pain: ☐ Sit ☐ Stand ☐ Walk ☐ Bend ☐ Squat ☐ Lay down ☐ Touch ☐ Up Stair

☐ Down Stair Movement ☐ Sleeping ☐ Other:_____

Alleviates/Decrease Pain: ☐ Sit ☐ Stand ☐ Walk ☐ other:_____

Patient's Name:_____ Id:_____ Date:_____

7. Are you presently working? __yes __no Occupation:_____
   a. If working, is it _____light/modified duty ___ regular duty
8. What type of exercise/hobbies do you do and how often? _____
9. Have you ever been diagnosed with any of the following? Circle all that apply.

Heart Problems	Osteoarthritis	High Thyroid	Alcohol Dependency
Pacemaker	Rheumatoid Arthritis	Low Thyroid	Stroke
High Blood pressure	Depression	GI Problems	TIA
High Cholesterol	Seizures	Fibromyalgia	Open Wound
Kidney Disease	Asthma	Infectious Disease	Gout
Diabetic	COPD	Drug Dependency	Other:_____

10. Have you ever had a broken bone or fracture? ___yes ___no If yes, which body part:_____
    _____
11. Have you ever had an autoimmune Disease? __yes __no If yes, what type, when diagnosed and managing provider. _____
12. Do you have a bleeding or clotting disorder? __yes __no If yes, what type and when diagnosed
    _____
13. Have you ever had cancer either past or present? __yes __no If yes what type and when diagnosed and name of oncologist._____
14. Please list any major surgeries with dates:
    _____
    _____
15. Any previous physical therapy, chiropractic care or other treatment? _____yes _____no
16. Do you smoke? ____yes ____no If yes, number of packs/day? _____
17. Do you ever drink alcohol? __yes __no How often?_____
18. Do you use caffeine? ____yes ____no
19. Are you pregnant? ___yes ____no
20. List ***any allergies to medication ,Chicken/ Egg , iodine/contrast/dye, and or latex:***
    _____
21. List ***ALL PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS*** you are currently taking or provide us with a separate list:
    _____
    _____
    _____
    _____
22. What are your goals for the program?
    _____
    _____
23. Is this a work-related injury? __yes __no If yes, will this be filed through your personal insurance or worker's compensation? _____