ACTIVECARE PHYSICAL THERAPY®

New Patient Intake Form

Patient Information

Patient Name:	☐ Male ☐ Female	**Today's Date:**
Birth Date: _____/_____/_____	**Age:**	**SS#:**

Personal Information

Mailing Address:	**Occupation:**
Suite/Apt No:	**Employer:** **How Long:**
City / State:	**Address:**
Zip Code:	**City / State:** **Zip Code:**
Email:	**Work Phone:**
Home Phone:	**Mobile Phone:**

Employment Information

Status: ☐ Single ☐ Married ☐ Divorced	**Spouse Name:**	**Children:** ☐ Yes ☐ No	**How Many?**

Emergency Contact Information

Contact Name:	**Home Number:**
Relationship:	**Mobile Number:**
Referring Physician Name:	**Specialty:**
Physician Address:	**Phone Number:**

Reason for Visit

Cause of Injury: ☐ Work ☐ Sports ☐ Auto ☐ Trauma ☐ Chronic ☐ Slip/Fall ☐ Repetitive

Date of Injury:

Explain what happened:

Description: ☐ Sharp ☐ Shooting ☐ Dull/Achy ☐ Sore ☐ Stiff ☐ Pins/Needles ☐ Tingling ☐ Burning ☐ Annoying ☐ Unstable ☐ Uncoordinated ☐ Weakness

Location of Pain:

Pain Scale Rating NOW: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
(circle one of the above)
At Best Pain Rating: _____ / 10 **At Worst Pain Rating:** _____ / 10

Condition of Injury: ☐ Comes/Goes ☐ Constant ☐ Getting Worse

Injury Interferes with: ☐ Work ☐ Sleep ☐ Daily Routine
Explain:

Similar Condition in the Past: ☐ Yes ☐ No
Explain:

Have you been treated by a MD or Chiropractor for this? ☐ Yes ☐ No

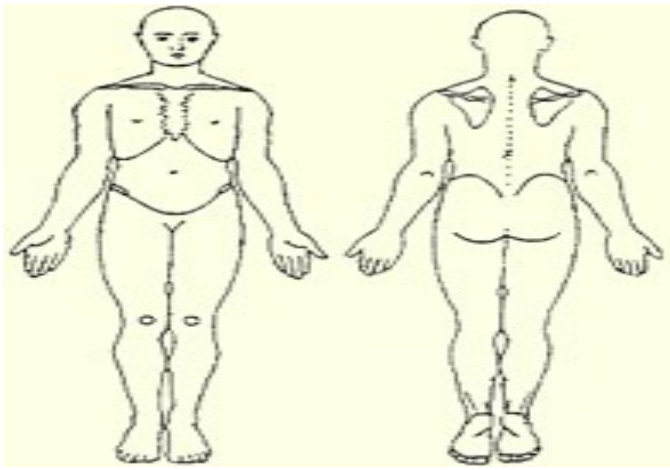
When?

Who?

When is your next Doctor's appointment?

Please (X) mark or circle the area of concern:

Hand Dominance : Right / Left



Health History

Are you taking any of the following medications? □ Nerve Pills □ Pain Killers (including aspirin) □ Muscle relaxers

□ Stimulants □ Blood Thinners □ Tranquilizers □ Insulin □ Other(s) _____

Y N Heart Attack / Stroke	**Y N** Heart Surgery / Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+ / AIDS	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema / Glaucoma	**Y N** Anemia
Y N High / Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe / Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers / Colitis
Y N Fainting / Seizures / Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes / Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Problems	**Y N** Artificial Bones / Joints	**Y N** Arthritis

Please list any other serious medical condition(s) you have/had:

Please list anything that you may be allergic to:

List previous surgeries/treatments with dates:

List any past serious accidents with dates:

Family Health History:

Do you take Supplements or Vitamins? □Yes □ No / Exercise? □ Yes □ No

Are you on a special diet: □ Yes □ No / Since: ____/____/____

Do you smoke? □ Yes □ No / How Much? _____ How Long? _____

Are you wearing: □ Heel Lifts □ Sole lifts □ Inner soles □ Arch supports

What is the age of your mattress? _____ Is it comfortable? □ Yes □ No

For Women: Are you taking Birth Control? □ Yes □ No

Are you Pregnant? □ Yes □ No / How long? _____ Nursing? □ Yes □ No

Authorization

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. **Our office files your claims to your insurance carrier(s) as a courtesy to you.** Your insurance coverage is a contract between you and your insurance carrier, thus your entire account balance, including those charges filed to your insurance company, remains your responsibility**.** Therefore, **you are responsible for follow-up communication with your insurance company should there be a problem in processing a claim.**
- Our policy requires payment in full for all services rendered at the time of visit. We accept cash, checks, and credit cards as payment. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- To give you the best possible service, we believe your time and our time is very valuable for treatment. **We have a strict late cancellation, reschedule or no show fee of $75. In order to not be charged, we require a 24-hour notice. Your card will be automatically charged.**
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and under-stand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:	Date: