ProCare Rehab & Wellness
PHYSICAL THERAPY

Physical Therapy Intake / Questionnaire

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____

Address: _____ **Home phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Cell Phone:** _____

****E-mail:** _____ **Occupation:** _____

Emergency Contact Person: _____ **Phone:** _____

Since January 1st, have you received any Physical Therapy/Occupational Therapy/Home Health Therapy?

☐ **No** ☐ **Yes**

If YES, How many visits were used? _____

IS YOUR CONDITION REALTED TO: 1. Work? (Current or Previous) □ YES □ NO

2. AUTO ACCIDENT? □ YES □ NO

Height: _____ **Weight:** _____ **How often do you exercise?** _____ **X Week.**

****How did you hear about ProCare Rehab?** _____

Referring Physician: _____ **Diagnosis:** _____

INSURANCE INFORMATION

☐ **Primary**

Insurance Company: _____ Phone: _____ Fax: _____

Policy/ID#: _____ Group#: _____

☐ **Attorney Information**

Attorney Name: _____ Assistant: _____

Phone: _____ Fax: _____

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Medical History Questionnaire

Name: _____ Date: _____

Please fill in the circles completely.

Female o Male o Age: `_____ Birthdate: _____ Occupation: _____

Have you received assistance from another medical specialist? *Please fill in the appropriate circle.*

	No	Yes (within last 12 months)	Yes (more than 12 months ago)
Acupuncture	o	o	o
Chiropractic	o	o	o
Massage	o	o	o
Naturopath	o	o	o
Osteopath	o	o	o
Other Physical Therapy	o	o	o
Psychologist	o	o	o
Vocational/Rehab Counselor	o	o	o

Other specialist. (*Please list, e.g. Orthopedist, Neurologist*) _____

Do you use an assistive device?

	No	Yes (*Community use only*)	Yes (*Home*)
Single-Point Cane	o	o	o
Quad Cane	o	o	o
Walker	o	o	o
Wheelchair	o	o	o

Other device/explanation. _____

Have you EVER been diagnosed as having any of the following conditions? *Please fill in the appropriate circle.*

	No	Yes	(Month//Year)		No	Yes	(Month//Year)
Lung Cancer	o	o	____/____	Skin Cancer	o	o	____/____
Breast Cancer	o	o	____/____	Bone Cancer	o	o	____/____
Prostate Cancer	o	o	____/____	Leukemia	o	o	____/____
Colon Cancer	o	o	____/____	Lymphoma	o	o	____/____

	No	Yes		No	Yes
Kidney infection	o	o	Chronic sinus infection	o	o
Pneumonia	o	o	Pelvic inflammatory disease	o	o
Bone or joint infection	o	o	Chronic urinary tract/bladder infection	o	o

Infectious Diseases . (Please list) _____

	No	Yes		No	Yes
Heart attack	o	o	High blood pressure	o	o
Heart valve problems	o	o	Anemic/low blood levels	o	o
Arterial blockage of the legs	o	o	Asthma	o	o
Diabetes	o	o	Emphysema	o	o
Stroke *(including transient ischemic attacks or mini strokes)*	o	o	Deep venous thrombosis *(blood clots in legs)*	o	o

	No	Yes		No	Yes
Chemical dependency *(i.e. alcoholism/drugs/tobacco use)*	o	o	Degenerative Osteoarthritis *(Wear-and-Tear Arthritis)*	o	o
Depression	o	o	Rheumatoid arthritis	o	o
Tuberculosis	o	o	Ankylosis spondylitis	o	o
Hepatitis	o	o	Stomach/duodenal ulcers	o	o
Hypo or low thyroid	o	o	Epilepsy/Seizures	o	o
Hyper or high thyroid	o	o	Endometriosis	o	o
Multiple Sclerosis	o	o	Headaches/Migraines *(>/1/week)*	o	o
Gout	o	o	Urinary incontinence	o	o

Other illnesses diagnosed by a physician. *(Please list)* _____

	No	Yes *(within last 12 months)*	Yes *(more than 12 months ago)*
Orthopedic/Joint surgery	o	o	o
Coronary bypass	o	o	o
Appendectomy	o	o	o
Gall bladder surgery	o	o	o
Prostate surgery	o	o	o
Caesarian section	o	o	o
Hysterectomy	o	o	o

Other surgeries. (Please list) _____

Have you had X-Ray – MRI – CTScan : _____

MEDICINE / MEDICATIONS:
Please list ALL medication you take, both prescription and non-prescription. *Please attach a separate page if necessary.*

_____

_____

Do you have any allergies (e.g., medicine, bees)?

_____

_____

Are you retired? No o Yes o

Are you currently working?

o Not working
Last day worked (Month/Day/Year): ____/____/____
Planning to return to work on (Month/Day/Year): ____/____/____

o Working , light duty
Restrictions _____
Hours working _____

o Working , full duty

Please describe the problem / condition that brought you to therapy:

How did your problem / condition begin: **Date symptoms started:** _____

What are you most hoping to get out of your therapy / activities you would like to return to:

Best time of day : _____ Worst time of day: _____

Activities / Positions that make you worse: _____

Activities / Positions that make you better: _____

For how many minutes can you perform the following activities comfortably?

Sitting _____minutes - Standing _____ minutes - Walking _____minutes - Sleeping _____ minutes

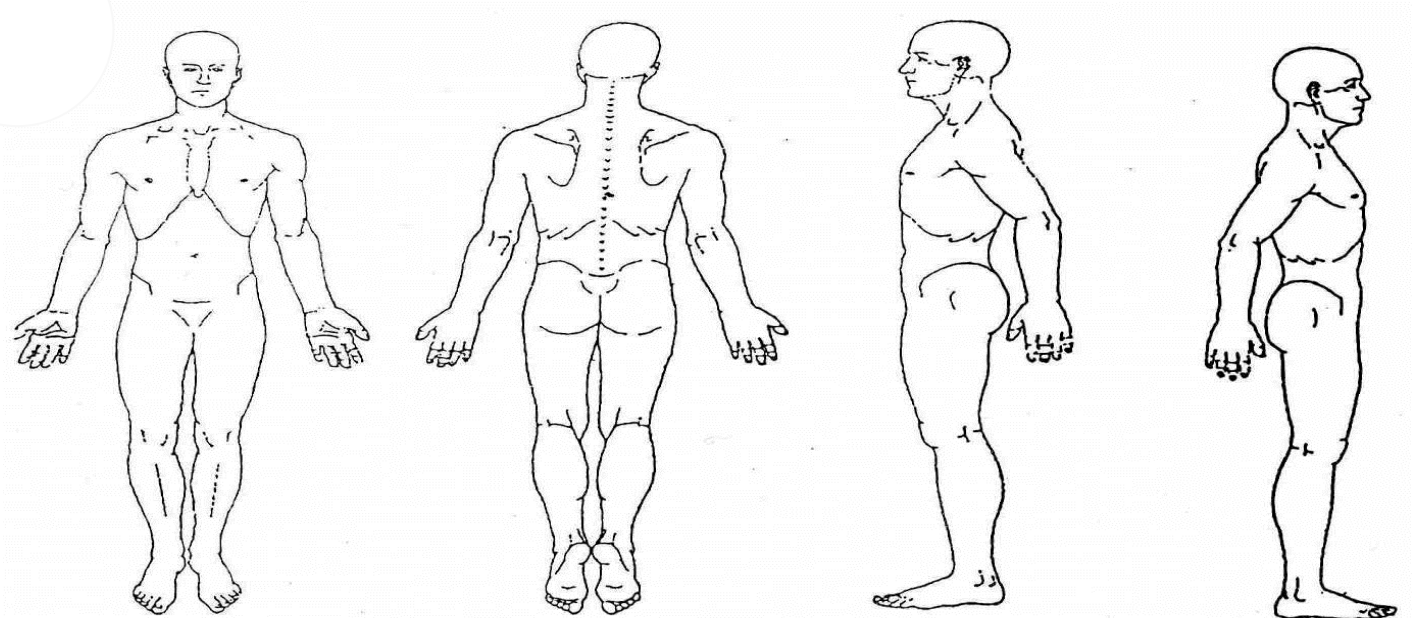
Do you Get: (Circle): Headaches – Blurred Vision – Loss of Balance – Fainting – Memory Loss – Dizziness

Circle two numbers below to indicate your pain at it's best and at it's worst over the last few days:

(No Pain) 0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10 (Severe pain)

Mark the areas where you feel the described sensations on your body. Use the appropriate symbol. Mark areas of radiation. Include all affected areas related to your current problem.

ACHE + + + + **NUMBNESS = = = =** **BURNING XXXX** **STABBING / / / / /**



I am signing this form to the best of my knowledge the information is accurate and reliable. I will notify provider if any information changes:

Patient or Authorized Representative Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

CONSENT FOR TREATMENT

I consent to have ProCare Rehab and Wellness Inc. and/or its affiliates to provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time. I authorize ProCare Rehab and Wellness Inc. to perform diagnostic test and give treatment as deemed necessary. By Signing below, I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risk, I hereby give my consent to that treatment.

AUTHORIZATION TO RELEASE MEDICAL RECORDS and ASSIGNMENT OF INSURANCE BENEFITS

I authorize ProCare Rehab and Wellness Inc., or its legal representative, to release to my insurance company or it representative any information including the diagnosis and the records of any treatment or evaluation rendered to me during the period of such care. I hereby authorize payment of medical benefits to which I am entitled to ProCare Rehab and Wellness Inc. for medical services rendered.

FINANCIAL AGREEMENT and PAYMENT POLICY

I understand that I am financially responsible for all charges whether or not paid by said insurance. These include deductible, co-payment, cost-share, and/or non-covered benefits. In the event of default, I shall be responsible for all costs of collection and reasonable attorney fees. Furthermore, I authorize payment of medical benefits to which I am entitled, to ProCare Rehab and Wellness Inc. for medical services rendered. I understand that payment is due at the time of service. We accept credit cards, cash, or personal checks.

APPOINTMENT CANCELLATION POLICY & CANCELLATION FEE SCHEDULE

We require 24 hours advance notice for any RESCHEDULE or CANCELLATION of scheduled appointments. This allows us reasonable time to offer your scheduled appointment time to other clients that may be on a wait list. We do have 24 hour answering machines for your convenience during non-working hours, weekends, and holidays.

In fairness to our other clients and staff we do charge a cancellation fee for appointments that are not kept, or which are cancelled with less than 24 hours notice. Cancellation fees must be paid in full at the time of your next appointment. Our cancellation fee schedule is as follows:

- No Fee for the first appointment missed or cancelled with less than 24 hours notice.
- $50 for each subsequent appointment missed or cancelled with less than 24 hours notice.

A special note for our clients who have Medicaid plans as their primary insurance. Due to the constraints of Medicaid, you are not subject to cancellation fees. However, upon your third cancellation with less than 24 hours notice, your case will be discharged and your physician will be notified of your progress to date and reason for discharge.

Regardless of cancellation fees paid, repeated cancellation or missed appointments will limit the therapeutic benefit of treatment. Depending upon your individual case and your particular insurance plan, we may be required to discharge you as a patient and notify your referring physician in the case of repeated cancellations or missed appointments.

I certify that the information I have provided above is correct. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

Patient / Parent / Guardian Signature	Relationship to Patient	Date

Witnessed By	Date

ASSUMPTION OF RISK AND RELEASE FOR PROCARE PHYSICAL THERAPY

I hereby represent, certify and warrant that I have received written permission from a certified medical practitioner in the State of Florida to participate in aquatic and/or land based physical therapy (hereafter referred to as physical therapy).

I also hereby acknowledge the inherent danger and risks involved in my participation in physical therapy or personal training provided by ProCare Rehab and Wellness Inc. I warrant that, during the entire time I participate in physical therapy or personal training provided by ProCare Rehab and Wellness Inc. it will be covered at my own expense for all activities related to or arising out of such participation by a private medical and liability insurance policy.

Understanding the above, I hereby covenant and agree that I assume all risks and responsibilities involved in participating in physical therapy through ProCare Rehab and Wellness Inc. and waive, release, and forever discharge ProCare Rehab and Wellness Inc. their owners, directors, officers, employees, agents, or any person acting on their behalf, from any and all claims, demands, liability, and damages relating to, arising out of, or resulting from my participation in physical therapy provided by ProCare Rehab and Wellness Inc.

I also covenant and agree to indemnify, defend and hold harmless ProCare Rehab and Wellness Inc , their owners, directors, officers, employees, agents, or any person acting on their behalf, from any and all claims, demands, damages, and liabilities, including but not limited to claims for personal injury, death, and property damage, by whomsoever brought, relating to, arising out of or resulting from my participation in physical therapy provided by ProCare Rehab and Wellness Inc., except for any loss, liability, injury, or damage caused solely by ProCare Rehab and Wellness Inc., their owners, directors, officers, employees, agents, or any person acting on their behalf. I also covenant and agree to reimburse ProCare Rehab and Wellness Inc. for each of their attorneys' fees, costs and expenses in connection with the defense of any such claim or demand.

HIPAA CONSENT: Health Insurance Portability and Accountability Act

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have a right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment, or health care operations.
2. The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
3. The practice reserves the right to change the notice of privacy practices.
4. The patient has the right to request restricted use of their information, but the practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosures will then cease.

The patient also understands that has adopted the following ProCare Rehab and Wellness Inc. policies:

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters relating to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers and health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. We sometimes remind patients of their appointments as a courtesy. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you.

I have read and consent to the assumption of risk and release and the HIPAA practices adopted by Procare Physical Therapy.
I understand that non-identifying patient data may be used in research and/or publication and consent to such use.

Patient / Parent / Guardian Signature _____ Relationship to Patient _____ Date _____

ProCare Rehab & Wellness
PHYSICAL THERAPY

Notice of Private Practices

Date: _____, Patient Name: _____

This is to certify that I, _____ have been given, offered or have seen the posted copy of the Notice of Private Practice (also known as HIPAA).

_____, Date _____
Signature of Patient/Guardian

_____, Date _____
Signature of Clinic Representative

Office Use Only:

I attempted to obtain the patient's signature in acknowledgment on the notice of Privacy Practice Form, but was unable to do so as documented below.

Date: _____, Initials: _____

Reason:_____
_____