OrthoSport Physical Therapy **Phone: (425) 670-9991**

Patient Intake Form

Patient Information

How did you hear about us?

Last Name: First Name: Middle Initial:

Address: apt # City: State: Zip Code:

Home Phone: Cell Phone: Email Address:

Date of Birth: SSN: Sex: □ Male □ Female Marital Status:

Employer Information

Employer Name: Employment Status: □ Full Time □ Part Time □ Retired □ Student

Address: City: State: Zip Code:

Work Phone Number: Patient Occupation:

Emergency Contact Information

Contact Name: Phone Number: Relationship to Patient:

Provider Information

Name of Referring Provider:_____ Telephone Number:_____

Primary Care Provider:_____ Telephone Number:_____

Additional Questions

Auto Related:	Work Related:	Accident Related:	Body Part/Diagnosis:	Date of Injury:
□ Yes	□ Yes	□ Yes		
□ No	□ No	□ No		

MEDICARE ONLY – Additional Questions

If Medicare, are you currently receiving Home Health Services? □ Yes □ No If yes, Name of Agency:_____

If Yes, what type of Home Health Services are you receiving?_____ Last date of service:_____

Are you currently residing in a Skilled Nursing Facility? □ Yes □ No If yes, Name of Facility:_____

If Medicare, have you received PT, OT or Speech therapy services since the first of the year? □ Yes □ No

-If yes, do you know if you have exceeded your Medicare Therapy Cap amount? □ Yes □ No

Insurance Information

Only complete the following if the Primary or Secondary policy holder is not the patient. □ **Primary** □ **Secondary**

Last Name: First Name: Middle Initial SSN: DOB:

Patient Relationship to Policy Holder: Gender: □Male □ Female

Employer Name: Employer Phone #:

Primary Insurance Section	**Secondary Insurance Section**
Payor/Plan:	Payor/Plan:
Policy/ID #:	Policy/ID #:
Group #:	Group #:

I consent to OrthoSport Physical Therapy, LLC for treatments/procedures that are necessary or advisable for my care. I hereby grant authorization to OrthoSport Physical Therapy, LLC to exchange with and/or release requested information on my medical care to my referring provider(s), insurance carriers, and all agencies involved in my case.

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits to OrthoSport Physical Therapy, LLC. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I understand no guarantee has been made concerning the results of treatment. I also certify that I have received the initial patient information/welcome letter from OrthoSport Physical Therapy, LLC.

Client's Signature **Date**

I have read and understood OrthoSport Physical Therapy, LLC's privacy notice. I further understand that I may obtain a copy of the privacy notice upon my request.

Client's Signature **Date**

I have read and understood OrthoSport Physical Therapy, LLC's billing and collection policies, initial disclosure, and cancellation and no show policies. I further understand that I may obtain a copy of this policy upon my request.

Client's Signature **Date**

Responsible Party's Signature (if patient is a minor) **Date**

Witness Signature **Date**

OrthoSport Physical Therapy

19217 36th Ave. West, Suite 102
Lynnwood, WA 98036

PATIENT HEALTH HISTORY FORM

NAME: _____Date:_____

Please list all medications that you are taking (both over the counter and prescriptions)
If you have a list, the front office will photocopy that for you.

_____
_____
_____
_____

Have you ever had an allergic reaction to: ☐ Lotion ☐ Perfume ☐ Gel ☐ Latex ☐ Adhesives?

Have you ever been diagnosed as having any of the following conditions?

☐ No ☐ Yes Cancer (if so, what type? _____)
☐ No ☐ Yes High blood pressure
☐ No ☐ Yes Asthma
☐ No ☐ Yes Chemical dependency (i.e. alcoholism)
☐ No ☐ Yes Diabetes
☐ No ☐ Yes Rheumatoid arthritis
☐ No ☐ Yes Depression
☐ No ☐ Yes Tuberculosis
☐ No ☐ Yes Kidney Disease
☐ No ☐ Yes Epilepsy
☐ No ☐ Yes Osteopenia/Osteoporosis

☐ No ☐ Yes Heart problems: _____
☐ No ☐ Yes Circulation problems
☐ No ☐ Yes Emphysema/Bronchitis
☐ No ☐ Yes Thyroid problems: _____
☐ No ☐ Yes Multiple Sclerosis
☐ No ☐ Yes Other arthritic conditions
☐ No ☐ Yes Hepatitis
☐ No ☐ Yes Stroke
☐ No ☐ Yes Anemia
☐ No ☐ Yes Incontinence
☐ No ☐ Yes Other _____

At the present time, would you say your health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

In the past month have you been feeling down, depressed or hopeless? _____

How much caffeinated or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

Have you recently noted:

☐ No ☐ Yes Weight loss/gain
☐ No ☐ Yes Dizziness/lightheadedness
☐ No ☐ Yes Weakness
☐ No ☐ Yes Numbness or tingling

☐ No ☐ Yes Nausea/vomiting
☐ No ☐ Yes Fatigue
☐ No ☐ Yes Fever/chills/sweats
☐ No ☐ Yes Bowel or Bladder leakage

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MEDICAL HISTORY/SUBJECTIVE INFORMATION

Your Name:				**Today's Date:**
	Age:	**Height:**	**Weight:**	
If female, are you currently pregnant? ☐ **No** ☐ **Yes If yes,** ☐ 1st ☐ 2nd ☐ 3rd Trimester				

Where and how did your injury/symptoms occur? ☐ Recreation ☐ Home ☐ Work ☐ Auto Accident ☐ Unknown ☐ Other

_____

What do you expect to accomplish with physical therapy? _____

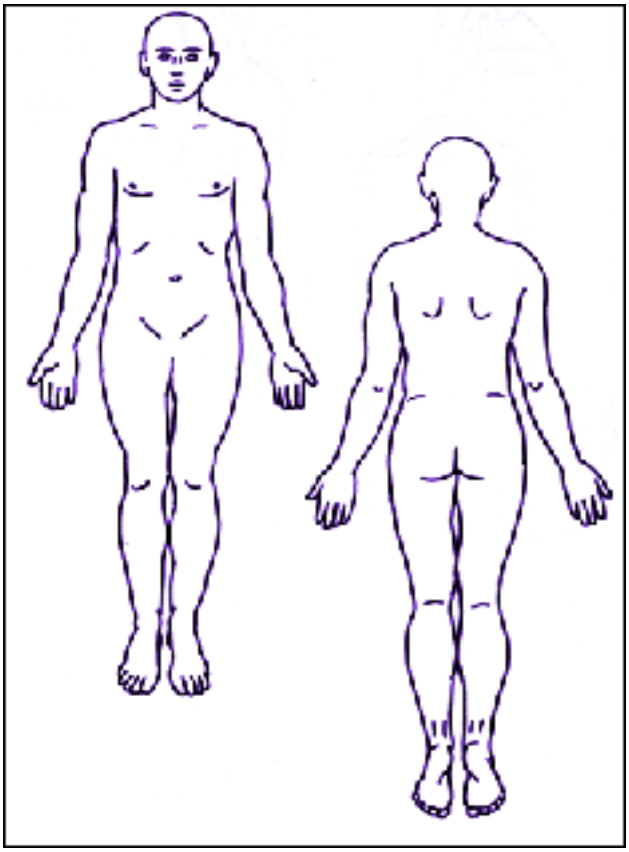
Are your symptoms: ☐Constant ☐Intermittent ☐Getting Better ☐Getting Worse ☐Staying the same?

What makes your symptoms better? _____

On a 0-10 pain scale (**0=No Pain and 10= The most extreme Pain**)

Worst pain rating: _____ **Best** pain rating: _____

Indicate on body diagram where your symptoms are located.
O = Pain /// = numbness/tingling



Are you here due to a recent surgery? ☐Yes ☐No
If yes, date of surgery: _____

Injury was the result of a fall in the past year? ☐Yes ☐No

I have had two or more falls in the past year? ☐Yes ☐No

Work Information

Are you currently working? ☐ No ☐ Yes If yes, numbers of hours per week _____☐ Full Duty ☐ Restricted Duty

What are your job responsibilities? _____

Estimated return to work date:_____