PATIENT PHYSICAL THERAPY INTAKE FORM

FULL NAME	DATE OF BIRTH	TODAY'S DATE
PHONE NUMBER	EMAIL	

HOW DID YOU HEAR ABOUT US? □ DOCTOR □ WEBSITE □ FRIEND □ OTHER: _____

HAVE THERE BEEN ANY CHANGES TO YOUR MEDICATIONS OR MEDICAL HISTORY SINCE YOUR LAST DOCTORS VISIT?
☐ Yes ☐ No IF YES, WHAT?

REASON FOR YOUR VISIT

CHIEF COMPLAINT OR MAIN PROBLEM

WHEN AND **HOW** DID THIS PROBLEM BEGIN?

AFFECTED SIDE ☐ Left ☐ Right ☐ Both

DIAGNOSTIC TESTS PERFORMED RELATED TO THIS PROBLEM ☐ X-ray ☐ MRI ☐ Other _____

IF YES, WHAT WERE THE RESULTS:

HAVE YOU RECEIVED TREATMENT FOR THIS PROBLEM PREVIOUSLY/CURRENTLY? ☐ Yes ☐ No

IF YES, WHAT TREATMENT?

WHAT WAS YOUR **PREVIOUS** FUNCTIONAL LEVEL BEFORE THE CURRENT INJURY/PROBLEM?

- □Independent in all activities
- □Needed assistance w/ self-care activities
- □Difficulty performing household chores
- □Lived alone
- □Lived with spouse/family member/caregiver
- □Assisted living
- □Other_____

WHAT ARE YOUR GOALS FOR THERAPY?

LIST ACTIVITIES THAT YOU HAVE DIFFICULTY WITH AS A RESULT OF YOUR PROBLEM/ILLNESS:

ABOUT YOUR PAIN

PAIN SCALE: 0 (NO PAIN) TO 10 (EXCRUCIATING PAIN) 0….1….2….3….4….5….6….7….8….9….10

PAIN LEVEL AT WORST: ___/10 CURRENT PAIN LEVEL: ___/10 PAIN LEVEL AT BEST: ___/10

PROGRESSION □ Getting Better □ Staying the Same □ Getting Worse

HOW WOULD YOU DESCRIBE YOUR PAIN?

□ Constant □Constant, but worse with activity □ Intermittent □ Intermittent, but worse with Activity □ Throbbing

□ Numbness/Tingling □ Sharp □ Dull □ Burning □ Achy □ N/A

WHEN IS THE PAIN WORSE?

□ Morning □ Afternoon □ Evening □ No consistent time of day

LIST ACTIVITIES OR POSITIONS THAT IMPROVE YOUR PAIN

MEDICAL HISTORY CHECK ALL THAT APPLY

▫ Alzheimer's	▫ Asthma	▫ Arthritis	▫ Blood Clots	▫ Head Injury
▫ Cancer	▫ Cardiovascular Disease	▫ Chest Pain	▫ Current Infection	▫ Diabetes
▫ Dizziness	▫ Falls	▫ Fainting	▫ Fibromyalgia	▫ Gout
▫ Head Aches	▫ Heart Disease	▫ Heart Surgery	▫ High blood Pressure	▫ Lung disease
▫ Multiple Sclerosis	▫ Muscular Dystrophy	▫ Nausea	▫ Osteoporosis	▫ Pacemaker
▫ Parkinson's Disease	▫ Shortness of Breath	▫ Stroke/TIA	▫ Swelling	▫ Unexplained Weight Loss

APPOINTMENT REMINDERS

I Decline any appointment reminders: □ (appointment print out only)

I Would like to receive appointment reminders: □ Please remind me using**:**

□ Text: _____ □ Phone Call: _____ □ Email: _____

CANCELLATION AND NO-SHOW POLICY

Cedar Point Wellness strives to provide each patient with the highest quality of care while attempting to accommodate your schedule. We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notification allows us to offer your time to another patient who is in need of services. Therefore, CPH has implemented the following 24-hour cancellation policy.

1) Physical therapy patients must provide our office **24-hours' notice to change or cancel an appointment.** Patients who do not arrive for a scheduled appointment or do not provide 24- hours' notice to change an appointment may be charged a cancellation fee if it becomes a repeated offense. This charge cannot be billed to insurance.

2) **If you arrive 15 minutes late for your visit, your appointment may need to be modified or cancelled and the 24-hour cancellation policy will apply.**

3) Your treatment plan has been established by your physical therapist to get you back to your regular activities as quickly as possible. Missing appointments may impede that process and prolong your recovery.

4) Repeated failure to comply with this policy will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment each day that you would like to receive therapy and our staff will do what they can to accommodate you as space on the schedule permits.

I HAVE READ THE CANCELLATION AND NO-SHOW POLICY:

PATIENT SIGNATURE: _____ DATE: _____

INFORMED CONSENT FOR PHYSICAL THERAPY SERVICES

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate healing to maximum functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Cedar Point Wellness does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

SIGNATURE DATE

PERSON SIGNING ON BEHALF OF PATIENT RELATIONSHIP TO PATIENT