



New Patient INTAKE FORM

How did you hear about us?

Doctor • ZocDoc • Internet search • Friend/Family • Post card • Sign • Other:.....

Personal Information

Name: _____ DOB: _____

Gender: Male / Female / Other Marital Status: Single / Married / Divorced

Address: _____ City _____ State _____ Zip _____

Phone#: Home: _____ Cell: _____

Email: _____

Emergency Contact

Name: _____ Relationship: _____

Phone#: _____

MEDICAL HISTORY

Primary Doctor _____ Referring MD _____

Date of Injury: _____

Surgery for this problem? Yes / No — Type _____ Date _____

Work-related? Yes / No - Auto accident? Yes / No

Outpatient PT this year? Yes / No - Home care now? Yes / No

Reason for today's visit: _____



Please check if apply.

- | | |
|--|--|
| ☐ Infectious Disease | ☐ Bladder or Bowel Problems |
| ☐ Cancer (Type): _____ | ☐ Sleeping Problems |
| ☐ Chemo/Radiation (Date): _____ | ☐ Do You Smoke? |
| ☐ Osteoporosis | ☐ Pacemaker |
| ☐ Latex Allergy / Sensitivity | ☐ Heart Disease |
| ☐ Arthritis / Swollen Joints | ☐ Stroke |
| ☐ Multiple Sclerosis | ☐ Blood Pressure |
| ☐ Thyroid Problems | ☐ Diabetes |
| | ☐ Others: _____ |

PATIENT RESPONSIBILITY & CONSENT

- **Scheduling:** Appointments are by reservation only.
- **Cancellations / Missed Visits:** 24-hour notice required. Less than 24 hours = \$70 fee (emergencies may be waived).
- **Payments:** Copays, deductibles, non-covered services due at visit. If insurance does not pay within 90 days after attempts, balance is patient responsibility.
- **Participation:** Attend visits as recommended and follow your home program.
- **No Warranty:** Results are not guaranteed; goals and options will be discussed.
- **Informed Consent:** Risks may include temporary soreness or symptom increase. Report concerns promptly.
- **Authorization:** I consent to treatment and authorize benefits/payment to the clinic. I understand my coverage and I am responsible for non-covered items.
- **Attendance:** I agree to attend ☐ week for ☐ weeks as recommended to support my recovery.

NOTICE OF PATIENT PRIVACY / HIPAA AWARENESS

We may use your health information for: Treatment, Payment, and Clinic Operations. Records may be shared with providers involved in your care and insurance when needed. Certain disclosures may be required by law (public health, court orders, worker's comp, emergencies, military).

You may:

- Request to review records (copies available at \$0.75/page)
- Request reasonable restrictions (clinic may or may not be able to honor)
- Revoke consent in writing (not retroactive)
- We may leave confidential messages or mail marked "private" related to your care and billing.

Patient/Guardian Signature: _____

Date: _____