DEMOGRAPHICS RECORDS

PATIENT INFORMATION

Injury/Diagnosis: ______________________

Referral Source: ______________________

First Name: ______________________

Middle Initial: ______

Last Name: ______________________

Gender: ☐ *Male* ☐ *Female*

Date of Birth: *mm* / *dd* / *yyyy*

SSN or ID #: ______________________

Marital Status: ☐ *Married* ☐ *Single* ☐ *Widowed* ☐ *Minor (under 18)*

Previous Patient? ☐ *Yes* ☐ *No*

If YES, what year: *yyyy*

Address: ______________________

City: ______________________

State: ______________________

Zip code: ______________________

Home Phone: ( )

Cell Phone: ( )

Email Address: @

Employer: ______________________

Occupation: ______________________

Emergency Contact: ______________________

Relationship to Patient: ______________________

Cell Phone: ( )

APPOINTMENT REMINDERS:

☐ **Email** ☐ **Voice Call** ☐ **Text** ☐ **No Reminder**

INSURANCE INFORMATION

Insurance Company: ______________________

Subscriber Name: ______________________

Subscriber Date of Birth: ______________________

Subscriber Employer: ______________________

Motor Vehicle Accident? ☐ *Yes* ☐ *No*

Work Related Accident? ☐ *Yes* ☐ *No*

Date of Injury: ______________________

Claim Number: ______________________

Claim Manager/Adjustor: ______________________

Phone Number: ______________________

PATIENT AUTHORIZATIONS

AUTHORIZATION FOR TREATMENT

I voluntarily consent to physical therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatments to be provided in this healthcare facility. I authorize Pro-Motion Phyiscal Therapy to provide such treatment.

INITIALS ___________

PAYMENT AUTHORIZATION

I request that payment be made on my behalf to Pro-Motion Physical Therapy for services furnished to me by Pro-Motion Physical Therapy. I authorize Pro-Motion Physical Therapy to release to the Centers for Medicare & Medicaid Services and its agents, any state Medicaide agency, and any other third party payor all medical or other information that is needed to determine the benefits payable for health services. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance including any reasonable collection fees required to collect delinquent accounts.
MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION AND I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT OF PHYSICAL THERAPY SERVICES RENDERED.

INITIALS ___________

RECORD RELEASE

I hereby authorize Pro-Motion Physical Therapy to release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, or other healthcare agencies, professionals, or persons who may provide health-care services deemed necessary for continuing my medical care.

INITIALS ___________

Please also release medical information regarding my physical therapy care to the following individual(s) (i.e., family members, coaches, trainers, etc.). It is not necessary to list physicians or insurance companies here.

NAME	RELATIONSHIP	PHONE NUMBER
______________________	________________	________________

HIPAA PRIVACY POLICY

I have been provided a copy of the HIPAA Privacy Policy for review and know that if I would like a copy of it to keep, I have requested one.

INITIALS ___________

CANCEL/NO SHOW POLICY

I have read and understand Pro-Motion Physical Therapy's Cancellation and No Show Policy and know that if I would like a copy of it to keep, I have requested one.

INITIALS ___________

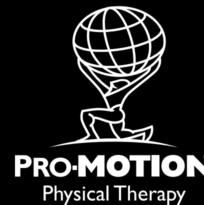
As part of working with my insurance carrier, I recognize that Pro-Motion Physical Therapy may be provided with information about my insurance coverage and that on occasion Pro-Motion Physical Therapy may share some of this information with me. However, I understand and acknowledge that Pro-Motion Physical Therapy is not responsible for the accuracy of any insurance coverage information shared with me, and that I am solely responsible for reviewing my insurance plan documents and/or working with my insurance carrier to determine the scope and details of any available insurance coverage. By signing below, I agree that I am responsible for the bill for any services rendered for myself or the patient for whom I am signing.

PATIENT PRINTED NAME: ______________________________ **DATE:** ________________

**PATIENT/REPRESENTATIVE/
PARENT/LEGAL GUARDIAN SIGNATURE:** ______________________________________

IF SIGNED BY PATIENT REPRESENTATIVE OR PARENT/LEGAL GUARDIAN, INDICATE RELATIONSHIP TO PATIENT: ________________

PATIENT INTAKE QUESTIONNAIRE



Patient Name: ______________________ Height: ______ Weight: ______

ABOUT YOUR CURRENT COMPLAINT:

1. What is the issue or reason for your visit today? ______________________

2. When did this begin? Date: __________ Has it recently worsened? Yes No Date: __________

3. Please let us know about your current situation...

   I can't or am unable to... ______________________

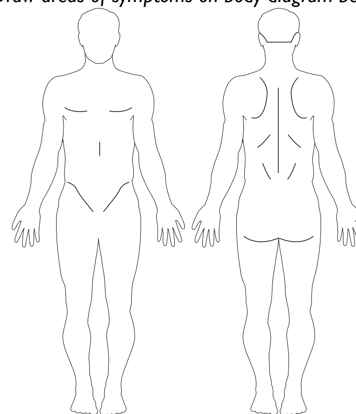
   I am hesitant or afraid to... ______________________

   It hurts when I... ______________________

4. Please rate your pain. *(on the scale of 0-10 place a check mark)*

	no pain				*moderate pain*					*severe pain*	
At your worst.	0	1	2	3	4	5	6	7	8	9	10
Currently.	0	1	2	3	4	5	6	7	8	9	10
At your best.	0	1	2	3	4	5	6	7	8	9	10

Draw areas of symptoms on body diagram below.



ABOUT YOUR GENERAL HEALTH

5. Rate your general health status. *(please circle one)*

   Good **Fair** **Poor**

6. Please check all medical conditions you have or have had.

Behavioral
- ☐ Anxiety
- ☐ Depression
- ☐ Tobacco Use

Cardiovascular
- ☐ Cardiovascular disease
- ☐ High blood pressure
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ High Cholesterol

Gastrointestinal
- ☐ Stomach Ulcers
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Gallbladder Problems

Musculoskeletal
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Fracture or suspected fracture
- ☐ Muscular dystrophy
- ☐ Osteoarthritis
- ☐ Rhematoid Arthritis
- ☐ Gout
- ☐ Osteoporosis

Pulmonary
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD

Neurological
- ☐ Alzheimer's
- ☐ Cauda equina syndrome
- ☐ Cerebral vascular accident
- ☐ Huntington's
- ☐ Parkinson's
- ☐ Traumatic brain injury
- ☐ Dizzy Spells
- ☐ Multiple Sclerosis
- ☐ Seizures

Urogenital
- ☐ Incontinence

Systemic
- ☐ Current infection
- ☐ Diabetes Mellitus
  - ☐ Type I
  - ☐ Type II
- ☐ History of cancer
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Obesity
- ☐ Autoimmune Disease
  type: __________
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Tuberculosis

- ☐ **Currently pregnant**
- ☐ **None**
- ☐ **Other** *(please specify)*
  ____
  ____

7. Please list any previous surgeries:
   (type and date) ______________________

8. What goals can we help you achieve?

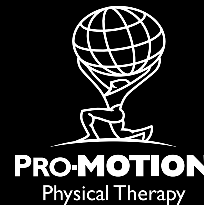
____

____

____

Pro Motion Physical Therapy 2006 W. Lincoln Ave. Ste. A, Yakima, WA 98902 509-573-4816

CANCELLATION AND NO SHOW POLICY



OUR POLICY:

We are sincerely concerned with helping you meet your goals of therapy. In order to do this, it is important that you attend ***all*** scheduled therapy appointments. Consistent attendance allows you and your therapy team to progress your treatment program which will result in a quicker recovery and better outcomes.

We realize that there are times when unforseen circumstances make it impossible to attend your scheduled appointment. If this happens, please give us as much notice as possible so we can reschedule the time for another patient and find another time for your appointment. Cancelling an appointment with short notice or not showing up for an appointment takes up clinic time that could benefit another person.

Please review the following policy, sign below and return to the front office staff. Should you have any further questions, please consult with your therapist.

Thank you for your cooperation.

Please read the following Cancellation and No Show Policy carefully and **initial next to each item.**

__________ If you cannot make it to your appointment, please contact our office at least 24 hours in advance to cancel your appointment.

__________ Our late cancellation fee is $40.

__________ If you miss 3 appointments without proper notice, all future appointments will be cancelled. You must pay any fees prior to additional visits Once fees are paid, you will be able to schedule 2 appointments at a time.

__________ No fees will be waived. Special circumstances will be handled on a case-by-case basis. If you intend to dispute the charge, you should speak with our Financial Officer.

Patient Name:____

Signature:____ Date:______________