

# PLYMOUTH PT SPECIALISTS PATIENT INTAKE AND CONSENT FORM

<b>Internal Use Only:</b>	Account # <input style="width: 80%;" type="text"/>	Account Type <input style="width: 80%;" type="text"/>	Office # <input style="width: 80%;" type="text"/>
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First Name _____ MI _____	Date of Injury/Onset _____ Today's Date _____
Last Name _____	Date of Birth _____ Age _____
Address _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
City _____ State _____ Zip _____	Home Phone _____
	Work Phone _____

Responsible Party _____
Address _____
City _____ State _____ Zip _____
Phone Number _____
Relationship to Responsible Party _____

Cell Phone _____
Injury Area _____
Accident Related: <input type="checkbox"/> Yes <input type="checkbox"/> No
If Accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other
Nature of Accident _____
SS# _____

Employer _____
Address _____
City _____ State _____ Zip _____

Occupation _____
Contact at Employer _____

Referring Physician _____	Phone Number _____
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Primary Insurance _____	Insured Name _____
Group # _____ ID # _____	Address _____ City _____
Insured Employer _____	State _____ Zip _____ Phone _____
Relationship to Insured _____	Insured Date of Birth _____ Insured Sex: <input type="checkbox"/> M <input type="checkbox"/> F

Second Insurance _____	Insured Name _____
Group # _____ ID # _____	Address _____ City _____
Insured Employer _____	State _____ Zip _____ Phone _____
Relationship to Insured _____	Insured Date of Birth _____ Insured Sex: <input type="checkbox"/> M <input type="checkbox"/> F

Emergency Contact _____	Daytime Phone Number _____
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Are you receiving or have you recently received home health services?  Yes  No

Are you receiving or have you recently received other therapy services?  Yes  No Please initial: \_\_\_\_\_

**CONSENT TO TREATMENT:** I consent to rehabilitation and related services at PLYMOUTH PT SPECIALISTS. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. \_\_\_\_\_

**TREATMENT OF MINORS:** I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. \_\_\_\_\_

**LIABILITY:** I know and agree that PLYMOUTH PT SPECIALISTS is not responsible for loss or damage to personal valuables. \_\_\_\_\_

**WAIVER AND RELEASE:** I hereby release, discharge and acquit PLYMOUTH PT SPECIALISTS, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. \_\_\_\_\_

**AUTHORIZATION OF PAYMENT:** I hereby assign all benefits directly to PLYMOUTH PT SPECIALISTS and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. \_\_\_\_\_

**NOTICE OF PRIVACY:** I acknowledge receipt of Notice of Privacy Practices. \_\_\_\_\_

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature \_\_\_\_\_ Witness Signature \_\_\_\_\_



# PLYMOUTH PHYSICAL THERAPY SPECIALISTS

Orthopedics • Sports Medicine • Industrial Rehabilitation

**Patient Name:** \_\_\_\_\_

## MEDICAL HISTORY

**Allergies:** \_\_\_\_\_

Are you currently seeing any of the following?

YES	NO	Medical Doctor (MD)	YES	NO	Chiropractor	YES	NO	Dentist
YES	NO	Osteopath (DO)	YES	NO	Physical Therapist	YES	NO	Podiatrist

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc): \_\_\_\_\_

Please indicate if you have EVER been diagnosed as having any of the following conditions: (answer all questions)

- Y N Cancer. If yes, describe what kind: \_\_\_\_\_
- Y N Heart problems \_\_\_\_\_
- Y N Pace maker \_\_\_\_\_
- Y N Circulation problems \_\_\_\_\_
- Y N High blood pressure \_\_\_\_\_
- Y N Stroke \_\_\_\_\_
- Y N Respiratory problems \_\_\_\_\_
- Y N Infectious disease \_\_\_\_\_
- Y N Hepatitis \_\_\_\_\_
- Y N Tuberculosis \_\_\_\_\_
- Y N Anemia \_\_\_\_\_
- Y N Thyroid problems \_\_\_\_\_
- Y N Kidney disease \_\_\_\_\_
- Y N Diabetes \_\_\_\_\_
- Y N Epilepsy \_\_\_\_\_
- Y N Rheumatoid arthritis \_\_\_\_\_
- Y N Other arthritic conditions \_\_\_\_\_
- Y N Currently pregnant \_\_\_\_\_
- Y N Metal or plastic implants \_\_\_\_\_
- Y N Osteoporosis \_\_\_\_\_

Please list ALL surgeries and dates \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

What are your symptoms at the present time? \_\_\_\_\_

What relieves your symptoms? \_\_\_\_\_

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

- Y N Aspirin
- Y N Tylenol
- Y N Advil/Motrin/Ibuprofen
- Y N Laxatives
- Y N Decongestants
- Y N Antihistamines
- Y N Antacid
- Y N Vitamins/mineral supplements
- Y N Other \_\_\_\_\_

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or patches): \_\_\_\_\_

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Have you recently noted:

- Y N Weight loss/gain
- Y N Nausea/vomiting
- Y N Fatigue
- Y N Weakness
- Y N Fever/chills/sweats
- Y N Numbness or tingling

**I have completed this form to the best of my knowledge and have not withheld any information.**

Form reviewed with patient? \_\_\_Yes \_\_\_No

\_\_\_\_\_  
Patient Signature      Date

\_\_\_\_\_  
Therapist Signature      Date



# PLYMOUTH

## PHYSICAL THERAPY SPECIALISTS

Orthopedics • Sports Medicine • Industrial Rehabilitation

**Patient Name:** \_\_\_\_\_ **Clinic:** \_\_\_\_\_  
(Please print clearly)

**Referring Doctor:** \_\_\_\_\_

### How did you hear about Plymouth Physical Therapy Specialists?

Please check only one box, Thank-you!

- AT&T Yellow Pages
- Gannett Hometown Phone Book
- Billboard
- Chamber of Commerce
- You are a current patient-Second Diagnosis
- Internet
- Yellow Pages.com
- PPTS Website
- Referred by Friend / Relative (NAME) \_\_\_\_\_
- Specifically Referred by Dr. to PPTS \_\_\_\_\_
- Expo Event or Presentation \_\_\_\_\_
- Referred by PPTS Employee \_\_\_\_\_
- Postcard \_\_\_\_\_
- Newspaper or Magazine \_\_\_\_\_
- List from Dr.'s Office (NAME if different from above) \_\_\_\_\_
- Athletic Trainer \_\_\_\_\_
- Other \_\_\_\_\_

May we add you to our email list to receive periodic newsletters, updates and events?

Please Circle: Y N

Email Address \_\_\_\_\_  
(Your email will remain confidential) Please print clearly.