HEALTH POINT
PHYSICAL THERAPY

Physical Therapy Intake Form

Name: _____ **Date:** _____

DOB: _____ **Sex:** Male Female

Address: _____

Phone Number: _____ **Email:** _____

Emergency Contact Name/Phone Number:_____

How did you hear about Health Point?_____

History

Exercise Frequency: _____

Do you smoke? If so, how often? _____

Are you pregnant? _____

Allergies: _____

List of medications: _____

Previous surgeries, if any: _____

Complaint

What is your major complaint? _____

Start date: _____ **Possible cause:** _____

Symptoms: _____

Previous doctors seen in regards to complaint: _____

Previous treatment for this condition:_____

Medications used to relieve pain: _____

Time of day symptoms are worst: _____

Rate current pain (circle choice): No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain experienced

Duration of pain (circle choice): Seldom Occasionally Constant

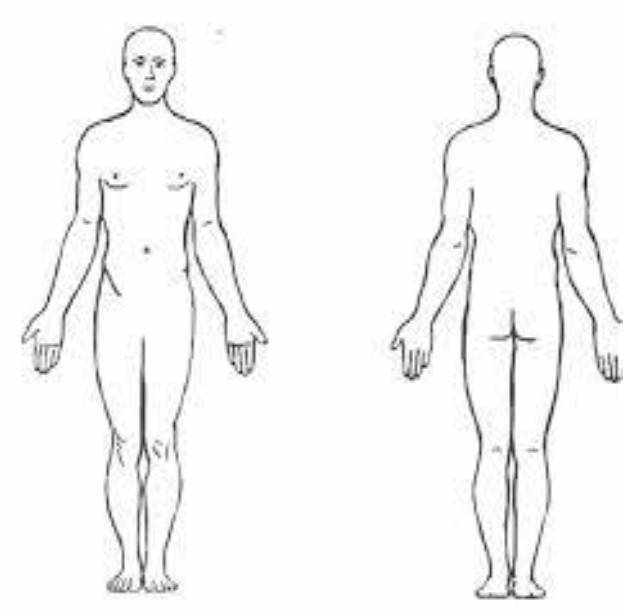
Is this your first time seeking treatment for this injury? _____

Do you have any of the following (check all that apply)

- Aids/HIV
- Anemia
- Asthma
- Epilepsy
- High/Low Blood Pressure
- Heart Problems
- Depression
- Multiple Sclerosis
- Liver Problems
- Pacemaker
- Pneumonia
- Arthritis
- Cancer
- Diabetes
- Lung issues
- Stroke
- Seizures
- Fractures
- Osteoporosis
- Frequent Falls
- Other_____

Mark area where pain is located:

Right **Left** **Left** **Right**



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Health Point Physical Therapy Authorization Form

This signed form is a recognition that under HIPPA laws, Health Point Physical Therapy will only send necessary documents under the request of either;

1. Patient's doctor or primary care physician
2. Patient's Insurance company or any party who accepts my assignment

Your signature below is needed in acknowledgement that you aware that Health Point Physical Therapy will only release your medical records to the parties said above.

Patient Name (Print): _____

Patient Signature:_____

Date: _____

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Financial Responsibility and Obligation Form

Health Point Physical Therapy is a health care provider who is authorized and credentialed to bill your medical insurance company to receive treatment. As a health care provider authorized by your insurance company we are obligated to collect all co-payments, deductibles, and out-of-pocket obligations according to your insurance plan or coverage. These regulations and standards are mandated by your insurance company for us to follow.

I,_____ understand that I am responsible for all charges not covered by my insurance coverage. This includes all copayments, deductibles, and out-of-pocket obligations.

Patient Name (Print): _____

Patient Signature:_____

Date: _____