VOLK PHYSICAL THERAPY & SPORTS MEDICINE

PATIENT INFORMATION

Mr.☐ Mrs.☐ Ms.☐ Dr.☐Last Name: _____ First Name _____Middle Initial_____

Gender: M☐ F☐ Date of Birth: _____/_____/_____ Social Security #: _____

Marital Status: S ☐ M ☐ Other ☐ Race_____ Email: _____

Patient's Address: _____City: _____ State: _____ Zip: _____-_____

Home Phone: _____-_____-_____ Cell: _____-_____-_____ Work Phone: _____-_____-_____

Contact Method: Phone ☐ Email ☐ Cell ☐ Text ☐ Text Enabled Y☐ N☐ No Appointment Reminder ☐___

Emergency Contact: _____ Phone: _____ Relationship: Parent ☐ Spouse ☐ Sibling ☐ Other ☐

EMPLOYER INFORMATION

Employer _____ Employment Status: FT ☐ PT ☐ Self-Emp ☐ None ☐ Ret ☐ Student ☐

Address: _____ City: _____ State: _____ Zip: _____-_____

Work Phone: _____ Occupation: _____

PHYSICIAN INFORMATION

Referring Physician: _____ Phone: (____)_____ Prescription Date:___/___/_____

Visits Ordered: ____ Injury/Onset Date: _____ Surgery: Y☐ N☐ Description:_____

Accident Type: None ☐ Work ☐ Auto ☐ (State ____) Other ☐ Body Part: _____

Have you had any prior therapy this year? Y☐ N☐ How did you hear about us? _____
(PT☐ OT☐ SP☐ Chiropractic☐)

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ Phone: _____-_____-_____

Policy/Claim #: _____ Group # or Name: _____

Insured Name:_____ Date of Birth: ____/____/____ SS#: _____-_____-_____

Relation to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐

SECONDARY INSURANCE INFORMATION

Insurance Name: _____ Phone: _____-_____-_____

Policy/Claim #: _____ Group # or Name: _____

Insured Name:_____ Date of Birth: ____/____/____ SS#: _____-_____-_____

Relation to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐

GUARANTOR INFORMATION

Persons Name: _____ Phone: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____-_____

Relation to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐

MEDICARE INFORMATION

If you have Medicare, are you currently receiving home health service? Y ☐ N ☐ If yes, name of agency: _____

Are you currently residing in a skilled nursing facility? Y ☐ N ☐ If yes, name of the facility: _____

Intake completed by: _____Please initial here if above information is complete _____ Date: ___/___/____

MEDICAL HISTORY

Chief Complaint: _____

Current Symptoms: Pain☐ Numbness☐ Stiffness☐ Weakness☐ New☐ Acute☐ Chronic☐

Medications Currently Taken: _____

Allergic to the Following Medications: _____

List Surgeries: _____

Previous Diagnostic or Rehabilitative Services for This Condition: MRI☐ Xrays☐ Other: _____

_____

Do you have any of the following?

	YES	NO
Asthma, Bronchitis, or Emphysema	☐	☐
Shortness of Breath/Chest Pain	☐	☐
Coronary Heart Disease	☐	☐
Do you have a Pacemaker	☐	☐
High Blood Pressure	☐	☐
Heart Attack/Surgery	☐	☐
Stroke/TIA	☐	☐
Blood Clot/Embolism	☐	☐
Epilepsy/Seizures	☐	☐
Thyroid Trouble/Goiter	☐	☐
Anemia	☐	☐
AIDS/HIV	☐	☐
Hepatitis	☐	☐
Infectious Disease	☐	☐
Diabetes	☐	☐
Cancer or Chemo/Radiation	☐	☐
Arthritis/Swollen Joints	☐	☐
Osteoporosis	☐	☐
Varicose Veins	☐	☐
Gout	☐	☐
Sleeping Difficulties	☐	☐
Emotional/Psychological Problems	☐	☐
Bowel or Bladder Problems	☐	☐
Severe Frequent Headaches	☐	☐
Vision/Hearing Difficulties	☐	☐
Dizziness or Faintness	☐	☐
Are you pregnant?	☐	☐
Smoking	Daily ☐	Weekly ☐
Alcohol Consumption	Daily ☐	Weekly ☐

Pain when performing the following activities?

	Mild	Moderate	Severe	Unable
Bending	☐	☐	☐	☐
Care for Infirm Family	☐	☐	☐	☐
Carrying Groceries	☐	☐	☐	☐
Change Pos (Sit to Stand)	☐	☐	☐	☐
Climb Stairs	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Extended Computer Use	☐	☐	☐	☐
Feeding (Self)	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Lift Children	☐	☐	☐	☐
Lifting	☐	☐	☐	☐
Pet Care	☐	☐	☐	☐
Reading (Concentration)	☐	☐	☐	☐
Self-Care-Bathing	☐	☐	☐	☐
Self-Care-Dressing	☐	☐	☐	☐
Self-Care-Shaving	☐	☐	☐	☐
Sexual Activities	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Sitting (Prolonged)	☐	☐	☐	☐
Standing (Prolonged)	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐
Sports	☐	☐	☐	☐
Recreational Activities	☐	☐	☐	☐

Exercise Daily ☐ Weekly ☐

Other Medical Conditions: _____

_____

Are you aware of your Diagnosis? YES ☐ NO ☐ Are you aware of your Prognosis? YES ☐ NO ☐

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Volk Physical Therapy regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: _____ Date: ____/____/___