# MOVEMENT PHYSICAL THERAPY PATIENT DATA SHEET

**First:** **MI:** **Last:**

**Date of Birth:** **Age:** **Gender:** Male ☐ Female ☐

**Physical Address:**

______________________
______________________
______________________
______________________

**Mailing Address:**

______________________
______________________
______________________

| **Phone Numbers:** | **OK To Call** | **Best Time To Call** |
|---|---|---|
| Home: ____ | ☐ | ____ |
| Work: ____ | ☐ | ____ |
| Cell: ____ | ☐ | ____ |

**May we send you text messages for your appointment reminders to the number(s) listed above?** ☐ Yes ☐ No

**May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above?** ☐ Yes ☐ No

**By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information**

**May we send you emails relating to your care with us?** ☐ Yes ☐ No
**By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.**
**Email:** ______________________

**Preferred language:** ______________ **Interpreter required?** ☐ Yes

**Date of Injury:** ______________ **Referring Physician:** ______________

**Injury Area:** ______________ **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

**State Where Accident Occured:** ______________

**Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days?** ☐ Yes ☐ No

**Are you currently receiving or have you received other therapy services in the last 60 days?** ☐ Yes ☐ No

**Marital Status:**

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

**Student Status:**

☐ Full-Time ☐ Part-Time ☐ None

## EMPLOYMENT STATUS

**Employment Status:**

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

**Employer:** ______________________ **Occupation:** ______________________

**Address:** ______________________________________________

______________________________________________

**Phone:** ______________________

**Employer:** ______________________ **Occupation:** ______________________

**Address:** ______________________________________________

______________________________________________

**Phone:** ______________________

## INSURANCE INFORMATION

**Primary Insurance:** ______________________

**Policy Holder's Name:** ______________________ **Holder's Birth Date:** ______________

**Policy or Certificate #:** ______________________ **Group #:** ______________

**Policy Holder's Employer:** ______________________

**Secondary Insurance:** ______________________

**Policy Holder's Name:** ______________________ **Holder's Birth Date:** ______________

**Policy or Certificate #:** ______________________ **Group #:** ______________

**Policy Holder's Employer:** ______________________

## How did you hear about us?

- [ ] Physician
- [ ] Employer
- [ ] Case Manager
- [ ] Former Patient
- [ ] Adjustor
- [ ] School
- [ ] Hospital
- [ ] Cross Referral
- [ ] Friend - Word of Mouth
- [ ] Attorney
- [ ] Self
- [ ] Screens - Open Houses
- [ ] Marketing Ad - Print
- [ ] Marketing Ad - TV
- [ ] Marketing Ad - Billboard
- [ ] Marketing Ad - Direct Mail - Email
- [ ] Marketing Ad - Facebook
- [ ] Marketing Ad - Other ________________

**Specify if other :** ____________________________________

**Note: Please provide us with the most updated information below.**

### EMERGENCY AND OTHER CONTACTS

| Name | Phone | Work | Cell | Fax | Type |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

____________________________________ ____________________________
Name Relationship

____________________________________ ____________________________
Name Relationship

__________________________________________________ _______________
**Signature of Patient** **Date**

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

**CONSENT TO TREATMENT**

I consent to rehabilitation and related services at: MOVEMENT PHYSICAL THERAPY

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:** ___________

**TREATMENT OF MINORS**

I, as a 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. **Initials:** ___________

**LIABILITY**

I know and agree that: MOVEMENT PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. **Initials:** ___________

**WAIVER AND RELEASE**

I hereby release, discharge and acquit: MOVEMENT PHYSICAL THERAPY its 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. **Initials:** ___________

**AUTHORIZATION OF PAYMENT**

I hereby assign all benefits directly to: MOVEMENT PHYSICAL THERAPY

I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. **Initials:** ___________

**FINANCIAL POLICY**

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.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.

**Initials:** ___________

**NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS**

I acknowledge receipt of Notice of Privacy Practices. **Initials:** ___________

I acknowledge receipt of the Statement of Patient Rights. **Initials:** ___________

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

**Patient/Guardian Signature** ________________________ **Witness Signature** ________________________ **Date** ____________

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of MOVEMENT PHYSICAL THERAPY. This form must be completed in its entirety and must be provided to MOVEMENT PHYSICAL THERAPY prior to initiation of therapy services. **Revised 4.5.21**

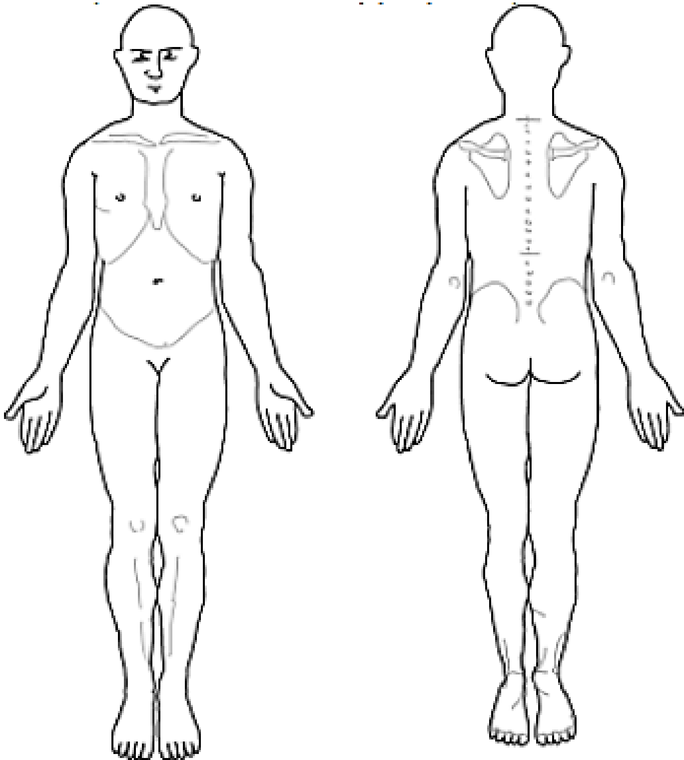
MOVEMENT PHYSICAL THERAPY

Patient account: ___________________

Name: ________________________________________ Birth Date: ________________ Today's Date: ______________

1) Reason for visit? ______________________________
______________________________________________

Localize areas of **pain** or **abnormal** sensation on the body chart below (shade in or circle where appropriate)



2) When did your symptoms begin? ________________
(Please indicate a specific date if possible)

3) Was the onset/timing of this episode?
◯ Gradual ◯ Sudden
Any previous episodes? ◯ Yes ◯ No

4) Is this related to the following?
◯ Work Injury ◯ Car Accident ◯ No

5) Since the onset are your symptoms? (check one)
◯ Improving ◯ Not Changing ◯ Worsening

6) Have you had any falls in the past year? ◯ No
◯ Yes How many times _______; Injured: ◯ Yes ◯ No

7) Nature of pain/symptoms (check all that apply)
◯ Sharp ◯ Aching ◯ Constant
◯ Dull ◯ Periodic ◯ Numbness/Tingling
◯ Throbbing ◯ Occasional ◯ Other ____________

8) As the day progresses, do your symptoms: (check one)
◯ Increase ◯ Decrease ◯ Stay the same

9) Does the pain wake you at night?
◯ Yes - If "yes", is it present: ◯ No
◯ While laying down ◯ Both
◯ Only when changing positions

10) In what position do you sleep? (check all that apply)
◯ Right side ◯ Left Side ◯ On Stomach
◯ On Back ◯ Chair/recliner

11) Since the onset of your current symptoms have you had: (check all that apply)
◯ any change in bowel or bladder function
◯ fever/chills
◯ numbness in the genitals or anal area
◯ numbness
◯ any dizziness or fainting
◯ unexplained weakness
◯ unexplained weight change
◯ night pain/sweats
◯ malaise (vague feeling of bodily discomfort)
◯ problems with vision/hearing
◯ none of the above

12) In the last 2 weeks how often have you been bothered by the following problems?
-Little Interest or pleasure in doing things?
◯ Not at all ◯ Several days
◯ More than one-half the days ◯ Nearly everyday
-Feeling down, depressed or hopeless?
◯ Not at all ◯ Several days
◯ More than one-half the days ◯ Nearly everyday

## Medical History

Do you have a pacemaker? ◯ Yes ◯ No
Are you pregnant? ◯ Yes ◯ No If Yes how many weeks: __________
Do you have a latex allergy? ◯ Yes ◯ No

Do you have or have you ever been diagnosed with:

| Yes No | | Yes No | | Yes No | | Yes No | |
|---|---|---|---|---|---|---|---|
| ◯ ◯ | Abnormal Bleeding | ◯ ◯ | Closed Head Injury | ◯ ◯ | Gout | ◯ ◯ | Multiple Sclerosis |
| ◯ ◯ | Angina | ◯ ◯ | Colitis | ◯ ◯ | Heart Disease | ◯ ◯ | MI (Heart Attack) |
| ◯ ◯ | Anxiety | ◯ ◯ | Congestive Heart Failure | ◯ ◯ | Hepatitis B | ◯ ◯ | Osteoarthritis |
| ◯ ◯ | Arrhythmia | ◯ ◯ | COPD | ◯ ◯ | Hepatitis C | ◯ ◯ | Osteoporosis |
| ◯ ◯ | Asthma | ◯ ◯ | CVA (Stroke) | ◯ ◯ | Hiatal Hernia | ◯ ◯ | Psoriatic Arthritis |
| ◯ ◯ | Bipolar Disorder | ◯ ◯ | Depression | ◯ ◯ | High Cholesterol | ◯ ◯ | PVD |
| ◯ ◯ | Bowel Incontinence | ◯ ◯ | Diabetes Type I | ◯ ◯ | HIV/AIDS | ◯ ◯ | Rheumatoid Arthritis |
| ◯ ◯ | Cancer | ◯ ◯ | Diabetes Type II | ◯ ◯ | High Blood Pressure | ◯ ◯ | Scoliosis |
| ◯ ◯ | Carpal Tunnel Syndrome | ◯ ◯ | DVT | ◯ ◯ | IBS | ◯ ◯ | Seizure Disorder |
| ◯ ◯ | Cellulitis | ◯ ◯ | Fibromyalgia | ◯ ◯ | Joint Pain | ◯ ◯ | Shortness of Breath |
| ◯ ◯ | Back Pain | ◯ ◯ | Frequent UTI | ◯ ◯ | Lymphedema | ◯ ◯ | TB |
| ◯ ◯ | Neck Pain | ◯ ◯ | GERD | ◯ ◯ | Migraines | ◯ ◯ | Urinary Incontinence |
| ◯ ◯ | Crohn’s Disease | ◯ ◯ | Glaucoma | ◯ ◯ | MRSA | | |

Other conditions not listed: ____________________________________________
____________________________________________

Surgical History: ____________________________________________
____________________________________________

Allergies: ____________________________________________
____________________________________________

### General Health

How would you rate your general health?
◯ Excellent ◯ Average ◯ Poor
◯ Good ◯ Fair

Previous Functional Level (check all that apply)
◯ Independent in all activities (work, community, home, recreation)
◯ Independent in all self-care activities (bathing, toileting, dressing, etc.)
◯ Difficulty performing self-care activities
◯ Need assistance with self-care activities
◯ Difficulty performing household chores
◯ Difficulty with activities in community outside of home

Do you exercise outside of normal daily activities?
◯ 5+ days/wk ◯ 3-4 days/wk ◯ 1-2 days/wk
◯ occasionally ◯ zero

Exercise, Sports/Recreation consisting of__________________
____________________________________________

What is your general stress level?
◯ Low ◯ Medium ◯ High

Caffeine Intake?
◯ None ◯ Occasional ◯ Moderate ◯ Heavy

Alcohol Intake?
◯ None ◯ Occasional ◯ Moderate ◯ Heavy

Smoking Status?
◯ None ◯ Former Smoker ◯ Current daily ◯ Occasional

If smoker how much?____________ ◯ Tobacco ◯ Marijuana

### Medications

Please list any prescription medications you are currently taking:
____________________________________________
____________________________________________

Are you currently taking any of the following over the counter medications?
◯ Asprin ◯ Advil/motrin/ibuprofen/Aleve
◯ Tylenol ◯ Antihistamine
◯ Vitamin/mineral supplements
◯ Other__________________________________

### Occupation Information

Occupation:________________________________
◯ Employed full time ◯ Student
◯ Employed part time ◯ Retired
◯ Self-employed ◯ Unemployed
◯ Homemaker ◯ Other__________________

Physical activities at work:__________________________
____________________________________________

### Living Environment

◯ Live alone ◯ Live with others
◯ Home/apartment ◯ Retirement complex
◯ Stairs (railing) ◯ Stairs (no railing)
◯ No stairs ◯ If stairs how many?__________
◯ Ramp ◯ Elevator
◯ Other__________________________________

Provider Signature: ___________________ Date: _________