MR #: Patient Name:

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| ADAMS COUNTY PHYSICAL THERAPY PATIENT DATA SHEET | | | | |
|---|----------------|---|--|--|
| First: | MI: | Last: | | |
| Date of Birth: | Age: | Gender: Male 🗌 Female 🗌 | | |
| Physical Address: | | Mailing Address: | | |
| | | | | |
| | | | | |
| | | | | |
| Phone Numbers: | OK To Call Bes | st Time To Call | | |
| Home: | | | | |
| Work: | | | | |
| Cell: | | | | |
| May we send you text me above? | • | appointment reminders to the number(s) listed | | |
| May we send you text me the number(s) listed abo | | eting Materials, including Patient review requests to No | | |
| By marking "Yes" above of unauthorized access | | l that text messages may NOT be secure, with a risk on | | |
| 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: | F | Referring Physician: | | |
| Injury Area: | | 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? | | | | |
| Are you currently receiving or have you received other therapy services in the last 60 days? | | | | |
| Marital Status: | | | | |
| Married Single | Divorced | Widowed Separated Unknown | | |
| Student Status: | | | | |
| 🗌 Full-Time 🗌 Part | -Time 🗌 None | 2 | | |

MR #: Patient Name:

| 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: | | | | | |

| MR #: Patient | Name: | | | | Page: 3/4 |
|------------------|-------------------|--------|------------------------|------------------------------------|-----------|
| How | did you hear abou | It us? |) | | |
| | Physician | | Hospital | Marketing Ad - Print | |
| | Employer | | Cross Referral | Marketing Ad - TV | |
| | Case Manager | | Friend - Word of Mouth | Marketing Ad - Billboard | |
| | Former Patient | | Attorney | Marketing Ad - Direct Mail - Email | |
| | Adjustor | | Self | Marketing Ad - Facebook | |
| | School | | Screens - Open Houses | Marketing Ad - Other | |
| Spe | cify if other : | | | | |

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

| EMERGENCY AND OTHER CONTACTS | | | | | |
|------------------------------|-------|------|------|-----|------|
| Name | Phone | Work | Cell | Fax | Туре |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| ve access to my medical and billing re | cords: |
|--|--------------|
| Relationship | |
| Relationship | |
| | Date |
| | Relationship |

| MR #: |
|---------------|
| Patient Name: |

PATIENT INTAKE AND CONSENT FORM

| Internal Use Only: | A/C# | Name | А/С Туре | Office # |
|--------------------|------|------|----------|----------|

CONSENT TO TREATMENT

I consent to rehabilitation and related services at: ADAMS COUNTY 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.

LIABILITY

I know and agree that: ADAMS COUNTY PHYSICAL THERAPY is not responsible for loss or damage to personal valuables.

Initials:

WAIVER AND RELEASE

I hereby release, discharge and acquit: ADAMS COUNTY 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: ADAMS COUNTY 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.

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.

| NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS Initials: 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 ADAMS COUNTY PHYSICAL THERAPY. This form must be completed in its entirety and must be provided to ADAMS COUNTY PHYSICAL THERAPY prior to initiation of therapy services. **Revised 4.5.21**

Medical History Form

| Patient Name: | | .Today's Date: | | |
|--|--------------------------|--------------------------|-----------------|--|
| Referring Physician: | | Date of Birth: | | Age: |
| Primary Care Physician: | | Date of Injury or Onset: | | |
| Date of Next Physician Appointment: | | | | |
| Reason for Therapy: | | | | |
| Cause of Injury or Onset: Accident | | r: If Other, plea | aa avalain: | |
| | | i. ii Other, pie | ase explain. | |
| Have you been hospitalized for the pres | | | , date: | |
| Did you have surgery for this condition If Yes, surgery type: | 1? 🗌 Yes 🗌 No | If Yes, date: | | |
| Are you currently receiving any other c If Yes, please describe: | are for the condition n | nentioned above? | ∐Yes ∐No | |
| Have you ever received therapy in the p | past for the condition i | mentioned above? | Yes No If Y | es, date: |
| Describe previous treatment: | | | | |
| Previous Treatment: Successful Un | successful | | | |
| Have you fallen in the last year? | | - | | u injured? □ Yes □ No ? □ Yes □ No |
| What are your personal goals/outcome | s you hope to achieve | from therapy? | | |
| | | | | |
| Describe your general health: Excel | llent 🗌 Good 🔲 Fair | Poor Do ye | ou smoke or use | tobacco? 🗌 Yes 🗌 No |
| DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply) | | | | |
| Allergies 🗌 Latex 🗌 Other | Dizziness | | 🗌 Kidney Pro | blems |
| 🗌 Anemia | ☐ Epilepsy or Seiz | ure Disorder | 🗌 Metal Impla | ints |
| Anxiety or Panic Disorders | Fainting | | | |
| 🗌 Arthritis 🗌 OA 📋 RA | ☐ Fatigue or Weak | ness | Multiple Sc | lerosis |
| 🗌 Asthma | Fever or Chills | | 🗌 Nausea / Vo | omiting |
| ☐ Use of Blood Thinners | Fractures | | | sis |
| Bowel or Bladder Disorder | ☐ Headaches | | Pacemaker | |
| ☐ Bleeding Disorder | Head Injury or C | oncussion | Parkinson's | s Disease |
| Cancer | 🗌 Hearing Impairm | ent | Peripheral 🗌 | Vascular Disease |
| 🗌 Chronic Cough | ☐ Heart Disease or | Heart Attack | Respiratory | or Breathing Problems |
| | 🗌 Hepatitis 🛛 A | □В□С | Ringing in | Ears |
| Congestive Heart Failure | 🗌 Hernia | | Sexual Dys | sfunction |
| Currently Pregnant | Blood Pressure | 🗌 High 🔲 Low | Skin Abnor | malities |
| Deep Vein Thrombosis (DVT) | HIV or AIDS | | Stroke or T | IA |
| Depression | 🗌 Hypoglycemia | | Thyroid Pro | oblems |
| □ Diabetes □Type I □ Type II □ Hypersensitivity to Hot or Cold | | ☐ Tuberculosis | | |
| List any other medical problems and explain: | | | | |

Medical History Form

| Medication List | | | | | |
|--|--------|-----------|--|--|--|
| Name of Medication | Dosage | Frequency | | | |
| Check Box if Medication List provided separately. | | | | | |
| 1. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other | | |
| 2. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other | | |
| 3. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other | | |
| 4. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other | | |
| 5. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other | | |
| 6. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other | | |
| 7. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other | | |
| 8. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other | | |
| 9. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other | | |
| 10. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other | | |
| 11. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other | | |
| 12. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other | | |
| Over the Counter Medications (check all that apply): Aspin Cough Medicine Allergy Relief Laxative Diet Pills | | | Cold Medicine: | | |
| Pain ScaleRate the severity of your pain by circling a box on the following scale.No PainWorst Pain12345678910On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location.KEY:A = AchingB = BurningN = Numbness O = Other | | | | | |
| Signature of Patient: | | DOB: | | | |
| Printed Name of Patient: | | Date: | | | |