PHYSICIANS REHABILITATION
SPECIALIZING IN BACK, NECK & KNEE PAIN

6150 Diamond Center Ct Bldg. 100 • Fort Myers, FL 33912 • **239.768.6396** • *Fax 239.204.3000*
5668 Strand Court. • Naples, FL 34110 • **239.687.2165** • *Fax: 239.330.1358*
4369 Tamiami Trail • Port Charlotte, FL 33980 • **941.467.1666** • *Fax: 941.312.2033*
3801 Bee Ridge Road Unit #9 • Sarasota, FL 34233 • **941.702.9575** • *Fax: 941.702.9980*
10935 SE 177th Place, Unit 406 • Summerfield, FL • **352-775-3339** • *Fax: 352-775-3340*

PATIENT INTAKE FORM

PATIENT INFORMATION

Social Security # _____-_____-_____

Date: _____

Last Name: _____First: _____M.I._____ Date of Birth _____/_____/_____

Local Address: _____ City: _____ State: _____ Zip:_____

Local Phone: _____Cell Phone: _____ Email: _____

Permanent Address_____ City: _____ State: _____Zip:_____

Marital Status (circle one): single married divorced widowed

Appointment Reminder Preference: (circle one) Voice call Text E-Mail

Employer: _____ Occupation: _____

Spouse or Parent:

Name: _____ Phone: (_____) _____

Address: _____City: _____ State _____ Zip_____

EMERGENCY CONTACT:

Name: _____Relationship: _____ Phone: (_____) _____

PRIMARY CARE PHYSICIAN: _____ Location: _____

Phone Number: _____ Fax Number: _____

INSURANCE INFORMATION:

Primary:

Policyholder or subscriber: _____ Insurance Company: _____

Id/Policy #: _____ Group #: _____

Secondary:

Policyholder or subscriber: _____ Insurance Company: _____

ID/Policy #: _____ Group #: _____

CONSENT OF TREATMENT:

I hereby authorize the professional staff at Physicians Rehabilitation to speak with me and perform an examination and treatment, if necessary, in order to determine if I am a candidate for [ ] Physical Therapy Only [ ]Osteoarthritic Knee Treatment, [ ] non-surgical spinal decompression, [ ] Neuropathy, [ ] OA Shoulder [ ] PRP and determine if the clinic will accept my case.

Patient Signature: _____ Date: _____

Patient Printed Name: _____ Date: _____

_____ Date: _____
Parent or Guardian Signature (if under 18)

_____ _____
Parent or Guardian Printed Name Staff/ Witness Signature & Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: Physicians Rehabilitation for professional/medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee and I agree to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment as required by my insurance policy. I understand that Physicians Rehabilitation is compliant with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance, adjuster or attorney for the purpose of securing payment under this insurance policy or to any medical provider associated with my case to effectively treat me, following HIPAA guidelines. The authorization is in effect until 90 days from the date the last bill is collected.

A photocopy of this Assignment shall be considered effective and valid as the original.

If there is anyone you would like authorize the disclosure of your Protected Health Information, medical or billing, you may specifically name the party below and initial next to what information you would like to disclose:

_____

Info related to diagnosis and physical therapy treatment ONLY _____Medical Billing Info ONLY _____Entire Record _____

Patient Signature _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Staff Witness Signature: _____ Date: _____

MEDICARE PATIENTS ONLY (Please circle Yes or No to each question below)

Y N Are your currently or have been treated by a physical, occupational, or speech therapist this calendar year?

Y N Are you covered by any Group Health Plan (GHP) through your current or former employment?
If YES, how many employees work for the employer providing coverage? _____

Y N Are you covered by any Group Health Plan (GHP) through a family member's current or former employment?
If YES, how many employees work for the employer providing coverage? _____

Y N Are you receiving Federal Black Lung Program benefits?

Y N Is your illness due to a work related accident/condition and is being covered by Workers Compensation?

Y N Is your illness or injury covered under Auto insurance, No-Fault insurance, medical payments coverage, per sonal injury insurance, liability insurance, or a medical "Set-Aside" account from a legal settlement?

Patient Condition

HISTORY & PRESENT ILLNESS FORM

How did you hear about our office? _____

How serious do you think your problem is? _____

In reference to severity, how would you rate it on a scale of 0-10? 0 1 2 3 4 5 6 7 8 9 10

What is the reason for prompting your request for a consultation? _____

_____

How do you view your problem?	MINIMAL	(Annoying but causing NO limitations)
(Circle One)	SLIGHT	(Tolerable but causing a little limitation)
	MODERATE	(Sometimes tolerable but causing limitations)
	SEVERE	(Causing significant limitations)
	EXTREME	(Causing constant limitations)

In your opinion and your own words, what do you think the real problem is? _____

_____

What are you hoping happens today as a result of the time spent with you? _____

_____

What 3 things has your pain caused you to miss most? _____

_____

How long has it been like this? _____

Please describe in detail the very first time you recall having this problem and what it felt like.

_____

_____

What changes or modifications have you had to make to your lifestyle since your problem began?

_____

_____

What actions or activities do you have trouble with or have limitations performing?

_____

_____

What kind of treatments have you received?

Surgeries: _____ How Many: _____ When: _____ How long did effects last: _____

Injections: _____ How Many: _____ When: _____ How long did effects last: _____

Chiropractic Care: _____ When: _____ How long did effects last: _____

Physical Therapy: _____ When: _____ How long did effects last: _____

Drugs/Pharmaceuticals: _____ When: _____ How long did effects last: _____

Other: (you may provide a copied list)

Did any of these treatments seem to work in helping your pain? Yes No

If yes, which one(s) and for how long? _____

_____

What actions can you take that temporarily decrease the pain? _____

_____

What activities or movements are guaranteed to increase your pain and worsen your condition?

_____

What does the pain feel like (sharp, dull, achy, toothache, shooting, stabbing, numb, tingling, etc..) and where?

_____

What does it feel like when you wake up compared to the rest of the day? _____

Is it worse in the morning or the evening? _____

What do you think will happen if you cannot find a solution to your pain or problem? _____

_____

What are you hoping the Doctor will tell you today? _____

Please express what you hope or imagine this state-of-the-art program and knowledge might be able to accomplish for you.

_____

Describe what will be different in your life if you can get better. _____

_____

List in order of importance all other health problems or concerns NOT including your main problem:

_____ How Long? _____

_____ How Long? _____

_____ How Long? _____

What percentage of time are you aware of your main problem? (Circle One)

Occasionally (25% of the time or less)

Intermittently (50% of the time)

Frequently (75% of the time)

Constantly (90-100% of the time)

Due to your problem…

Have you lost any time from work? Yes No

If yes, how much time and what have you been unable to perform?_____

_____

Have you lost any time from your obligations at home? Yes No

If yes, how much time and what chores have been limited at home?_____

Have you lost any time from your family? Yes No

If yes, how much time and what tasks have been limited?_____

Have you lost any time enjoying your leisure activities? Yes No

If yes, how much time and what activities have been limited?_____

How long has your pain been this severe?_____

On a scale of 0-10 (0 being no pain or discomfort, 10 being unbearable) please rate the following (circle your selections):

The HIGHEST your pain gets WITHOUT medication:	0	1	2	3	4	5	6	7	8	9	10
The LOWEST your pain gets WITHOUT medication:	0	1	2	3	4	5	6	7	8	9	10
The HIGHEST your pain gets WITH medication:	0	1	2	3	4	5	6	7	8	9	10
The LOWEST your pain gets WITH medication:	0	1	2	3	4	5	6	7	8	9	10

List any surgeries you have had and the corresponding dates:

Date:	Surgery:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please sign indicating that all information given is accurate to the best of your knowledge:

Patient Signature: _____ Date: _____

Patient Printed Name: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____