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### PATIENT INTAKE AND CONSENT

#### Personal and Insurance Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: (cell) \_\_\_\_\_ (work) \_\_\_\_\_ (home) \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: Male/Female (circle)  
Email: \_\_\_\_\_  
Emergency Contact and Phone: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Responsible Party: (If patient is under 18 yrs parent/guardian info MUST be provided here)  
Responsible Party's Full Legal Name: \_\_\_\_\_ Gender: Male/Female  
Billing Address: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_  
Reason for Visit: \_\_\_\_\_ Date of Onset: \_\_\_\_\_  
Employment Status: working, self-employed, retired, student, on disability, other \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Physician (if applicable): \_\_\_\_\_  
How did you hear about Core PT? \_\_\_\_\_

#### Consent for Physical Therapy

\_\_\_\_\_ I do hereby agree and give my consent for Core Physical Therapy to furnish medical care and treatment as considered necessary and proper in diagnosing or treating my physical condition.

\_\_\_\_\_ I will allow the use of filming devices for the purpose of enhancing my care. I consent to the transmittal of such filming images to the treating physician through email or text. The images will only be used for treatment purposes.

\_\_\_\_\_ I have read and been notified of Core Physical Therapy's Notice of Privacy Practices.

**BENEFIT ASSIGNMENT/RELEASE OF INFORMATION** I, the undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medigap, DMAS, private insurance and third party payers, to Core Physical Therapy. I hereby authorize to release all information necessary, including medical records, to secure payment. Furthermore, Core Physical Therapy reserves the right to make changes to our privacy policy at any time in order to remain in compliance with state and federal regulations.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical History (current or previous)

Check all that apply.

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> allergies/asthma   | <input type="checkbox"/> fibromyalgia         | <input type="checkbox"/> hepatitis           | <input type="checkbox"/> HIV/AIDS           |
| <input type="checkbox"/> dizziness          | <input type="checkbox"/> osteoarthritis       | <input type="checkbox"/> smoking             | <input type="checkbox"/> thyroid disease    |
| <input type="checkbox"/> diabetes           | <input type="checkbox"/> fractures            | <input type="checkbox"/> pacemaker           | <input type="checkbox"/> currently pregnant |
| <input type="checkbox"/> MRSA               | <input type="checkbox"/> osteoporosis         | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> incontinence       |
| <input type="checkbox"/> anemia             | <input type="checkbox"/> chest pain           | <input type="checkbox"/> low blood pressure  | <input type="checkbox"/> tuberculosis       |
| <input type="checkbox"/> liver disease      | <input type="checkbox"/> headaches            | <input type="checkbox"/> heart disease       | <input type="checkbox"/> depression         |
| <input type="checkbox"/> lung disease       | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> chemical dependency | <input type="checkbox"/> kidney problems    |
| <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> cancer               | <input type="checkbox"/> high cholesterol    | <input type="checkbox"/> metal implants     |
| <input type="checkbox"/> anxiety            | <input type="checkbox"/> seizures             | <input type="checkbox"/> strokes             | <input type="checkbox"/> ulcers             |

Please elaborate on any conditions above or add any not listed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any surgeries? If so please list. \_\_\_\_\_  
\_\_\_\_\_

Do you take blood thinners? \_\_\_\_\_

Are you allergic to latex? \_\_\_\_\_

Any other allergies? \_\_\_\_\_

Currently, are you experiencing any of the following? Check all that apply.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> unexplained weight loss | <input type="checkbox"/> change in appetite      | <input type="checkbox"/> loss of bladder or bowel control                        |
| <input type="checkbox"/> fever/chills            | <input type="checkbox"/> increased pain at night | <input type="checkbox"/> numbness/tingling                                       |
| <input type="checkbox"/> dizziness               | <input type="checkbox"/> shortness of breath     | <input type="checkbox"/> feeling of hopelessness/little pleasure in doing things |

Please list any medications you are currently taking. If you have a list, we can copy.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_  
\_\_\_\_\_