922 University City Blvd, Suite 204
Blacksburg, Virginia 24060
Phone: 540-315-3000
Fax: 540-739-3692

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.

<u>BENEFIT ASSIGNMENT/RELEASE OF INFORMATION</u> 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.

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

Please elaborate on any conditions above or add any not listed: ______________________________

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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.

- ☐ unexplained weight loss
- ☐ fever/chills
- ☐ dizziness
- ☐ change in appetite
- ☐ increased pain at night
- ☐ shortness of breath
- ☐ loss of bladder or bowel control
- ☐ numbness/tingling
- ☐ feeling of hopelessness/little pleasure in doing things

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

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Height: ______________ Weight: ______________

What are your goals for therapy? ______________________________

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