Energize Physical Therapy New Patient Intake Form ***Date of Appointment:*** ____________

PATIENT INFORMATION

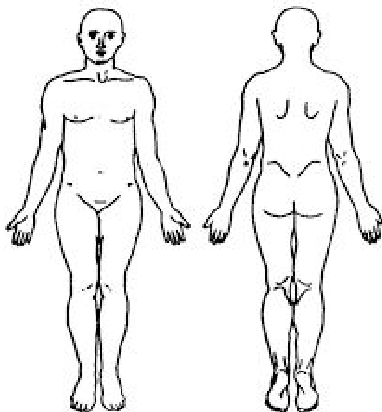
First Name	Middle Name	Last Name
Sex	**Date of Birth**	**Social Security Number**
Address		
Mobile Phone	**Home Phone**	**Email Address**
How did you hear about our clinic?	**Primary Care Physician**	**Primary Care Physician Phone**
Primary Health Insurance	**ID Number**	**Insurance Termination Date**
Secondary Health Insurance	**ID Number**	**Insurance Termination Date**

EMERGENCY CONTACT INFORMATION

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

REASON FOR VISIT

Your current injury/condition: ______________________________ Date of Onset: ____________________



← **Please indicate where your symptoms are**

Describe the pain
(numbness, tingling, burning sensation, achy, sharp, etc.)

____

____

MEDICARE PATIENTS ONLY

Have you had physical therapy this year? ☐ Yes ☐ No # of visits ____________
Have you had home therapy this year? ☐ Yes ☐ No
Are you receiving home therapy? ☐ Yes ☐ No
Do you have a home health aide? ☐ Yes ☐ No
Have you had any falls this past year? ☐ Yes ☐ No
Height: ____ feet ____ inches
Weight: ____ lbs

SURGERIES: Date of Surgery:

CURRENT MEDICATIONS:

ALLERGIES:

PAST MEDICAL HISTORY

- ☐ Pacemaker
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Anemia
- ☐ Gout
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Hernia
- ☐ Vision/Hearing Issues
- ☐ Infectious Disease
- ☐ Infectious Disease
- ☐ Blood Clots
- ☐ Stroke/TIA
- ☐ Osteoarthritis
- ☐ Seizures/Epilepsy
- ☐ Incontinence
- ☐ Weakness/Fatigue
- ☐ Recent Weight Loss
- ☐ Pregnant

PATIENT AGREEMENT FORM

Thank you for choosing Energize Physical Therapy. To facilitate your treatment, please review and sign the following agreement and authorization.

1) **Consent to Treatment:**
I hereby agree to give consent for Energize Physical Therapy P.L.L.C., to provide medical care and treatment as deemed necessary by the physical therapist.

2) **Authorization for Release of Medical Information:**
I hereby authorize Energize Physical Therapy P.L.L.C., to release any medical information or statement charges pertaining to my physical therapy care to insurance carriers, government agencies, as well as others who are financially liable for my care.

3) **Financial Responsibility:**
I agree to pay for all services rendered by Energize Physical Therapy P.L.L.C. I understand that in the event that Medicare or a third-party insurance carrier does not cover services rendered, I am responsible for the full amount due. I understand that all payments are due at time of service, including any deductible, co-insurance/co-payments required by your insurance carrier. I understand that when changes are made to my insurance coverage, I am to notify the staff prior to my next visit.

Copayment Amount: _______ Patient Initials: _______ **Deductible Amount:** _______ Patient Initials: _______

4) **Cancellation Policy:**
All cancellations must be made at least 24 hours in advance.
Failure to do so will result in a **cancellation fee of $25** that is not covered by insurance.
We reserve the right to deny treatment if you do not show for your appointment 3 consecutive times.

I acknowledge that I have been provided a copy of Energize Physical Therapy P.L.L.C.'s Notice of Privacy Practices. (You have a right to refuse to sign this acknowledgment if you choose so)
By signing below, I agree to all the terms and conditions and voluntary consent to physical therapy treatment.

____
Print Name

______________________________ _____ / _____ / _________
Patient/Guardian Signature *Date*