ROBA
PHYSICAL THERAPY
AND WELLNESS

PATIENT DEMOGRAPHICS
INTAKE FORM

GENERAL INFORMATION

Name - First: _____ Last: _____ Gender: _____

Date of Birth:_____ Phone: _____ Home Phone: _____

Email:_____

Primary Care Physician:_____ Phone Number: _____

Occupation:_____

Have you had PT in the last 12 months? No Yes - Approximately how many visits _____

How did you hear about this clinic?_____

HEALTH INSURANCE INFORMATION

Please be sure you are familiar with your health plan's benefits for PT. (i.e. co-pay, deducible, number of visits allowed, authorization/referral requirements)

Insurance Type:_____

Member ID/Policy #:_____ Subscriber's Name:_____

Relationship:_____ Subscriber's Date of Birth:_____

Secondary Insurance (Type & ID) #:_____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:_____

Relationship:_____

Home Phone #:_____ Cell Phone #:_____

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MEDICAL HISTORY
INTAKE FORM

Describe your current problem and how it began:_____

_____

Onset Date: _____ **This problem is from:** *Sports: ____Work: _____ Car Accident:_____Other:_____*

Describe the nature of your pain: *Sharp:_____Dull Ache: _____Shooting: _____ Tingling:_____ Other:_____*

My symptoms are present: *Constantly (76-100% of the day)____ Occasionally (26-50% of the day)_____*

Frequently (51-75% of the day) _____ Intermittently (0-25% of the day)_____

What makes your symptoms worse? *Sitting for x mins _____ Standing for x mins _____ Walking for x mins _____ Stairs _____ Lying Down _____ Standing up from a chair _____ Reaching overhead _____ Reaching behind back _____ Other:_____*

What makes your symptoms better? *Sitting ____Standing ___ Lying down ____ Walking ___ Massage ___ Chiropractor _____*

Ice ____Heat ____Rest _____Other:_____

Current Pain *(0-10)*:_____ **Pain at Worst** *(0-10)*:_____ **Pain at Best** *(0-10):*_____

How is your condition changing: *Getting better ____ Getting worse ____ Not changing ____*

Who have you seen for this condition (please list name)?

Medical Doctor: _____Chiropractor: _____
Massage Therapist: _____ Physical Therapist: _____
Acupuncturist: _____ □ Other: _____

Have you had imaging (x-rays, MRI, CT Scan) for this problem? *No ____Yes (details):_____*

How would your rate your overall health right now? *Excellent____Very Good ___ Good ____ Fair ____ Poor ____*

Do you exercise regularly? *No ____ Yes, _____How often & what type? _____*

Recreational Activities/Hobbies:_____

Past Medical History: _____

Current Medications (name & dosage) _____

Prior injuries (injury & date): _____

Prior surgeries (type & date): _____

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Acknowledgement of Privacy Practices

I have received, read, and understood the notice of privacy practices which has provided a complete description of the uses and disclosures of my health information as outlined by the Health Insurance Portability and Accountability Act of 1996. I understand that I have certain rights regarding my protected health information and that this information can and will be used for purposes of treatment, payment and normal healthcare operations.

Consent to Treatment

I, the undersigned, a patient at Roba Physical Therapy and Wellness, do hereby authorize the licensed physical therapy staff to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and me. Furthermore, I understand that Roba Physical Therapy and Wellness will prepare insurance forms, and will bill only as a courtesy my insurance company directly. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Deductibles/Percentages pays and/or Co-payments: Co-payments along with partial payment toward deductibles and co-insurance are to be paid at time of service. Payment for any remaining balance after claims process is due at time of next visit or upon receipt of statement, whichever is sooner. All patients with an insurance deductible or co-insurance will be asked to make a pre-payment at each visit, which will be credited after claims are processed by insurance.

Cancellation/No-Show Policy

Cancellations should be made at least 24 hours prior to my scheduled appointment. Our time is valuable too – if you do not show up for a scheduled appointment, or neglect to cancel 24 hours prior to your appointment, you will be charged a $50 no-show/late cancel fee.

Insurance Referrals

Patients are responsible to insure referrals and authorizations required by insurance companies are obtained. As a courtesy, Roba Physical Therapy and Wellness will assist the patient with this process. Patients will be held responsible for the cost of visits that are denied by insurance because a referral or authorization was not obtained.

By signing below you are agreeing to acknowledgement of privacy practices along with all the terms and conditions listed above.

Printed Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____