MR #:
Patient Name:

GREEN OAKS PHYSICAL THERAPY PATIENT DATA SHEET

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

Mailing Address:

Phone Numbers: **OK To Call** **Best Time To Call**

Home: ☐

Work: ☐

Cell: ☐

May we send you text messages for your appointment reminders to the number(s) listed above? ☐ Yes ☐ No

May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above? ☐ Yes ☐ No

By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email:

Preferred language: **Interpreter required?** ☐ Yes

Date of Injury: **Referring Physician:**

Injury Area: **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

State Where Accident Occured:

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: **Occupation:**

Address:

Phone:

Employer: **Occupation:**

Address:

Phone:

INSURANCE INFORMATION

Primary Insurance:

Policy Holder's Name: **Holder's Birth Date:**

Policy or Certificate #: **Group #:**

Policy Holder's Employer:

Secondary Insurance:

Policy Holder's Name: **Holder's Birth Date:**

Policy or Certificate #: **Group #:**

Policy Holder's Employer:

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other

Specify if other :

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

Name Relationship

Name Relationship

Signature of Patient

Date

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at: GREEN OAKS PHYSICAL THERAPY

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:** _____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:** _____

LIABILITY

I know and agree that: GREEN OAKS PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. **Initials:** _____

WAIVER AND RELEASE

I hereby release, discharge and acquit: GREEN OAKS PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Initials:** _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: GREEN OAKS PHYSICAL THERAPY
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. **Initials:** _____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. **Initials:** _____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:** _____
I acknowledge receipt of the Statement of Patient Rights. **Initials:** _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ **Witness Signature** _____ **Date** _____

GREEN OAKS PHYSICAL THERAPY ORTHOPAEDIC SPINE & SPORTS

Medical history

Patient name: _____ DOB: _____ Date: _____

Primary reason for visit (select 1)

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Shoulder or arm problems
- ☐ Hand problems
- ☐ Leg or foot problems
- ☐ Balance problems
- ☐ Speech problems
- ☐ Swallowing problems
- ☐ Other

Date condition began _____ Is this a work related injury? ☐ Yes ☐ No

Date of Surgery (if applicable) _____ Type of surgery _____

Date of next doctor appointment for this condition _____

Secondary reason for visit (if applicable)

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Shoulder or arm problems
- ☐ Hand problems
- ☐ Leg or foot problems
- ☐ Balance problems
- ☐ Speech problems
- ☐ Swallowing problems
- ☐ Other

Date condition began _____ Is this a work related injury? ☐ Yes ☐ No

Date of Surgery (if applicable) _____ Type of surgery _____

Date of next doctor appointment for this condition _____

Please describe the onset and history of the current condition(s):

_____

_____

_____

Have you fallen in the past 12 months? ☐ Yes ☐ No If yes, how many times? _____

Have any falls resulted in injury? ☐ Yes ☐ No Do you worry about falling? ☐ Yes ☐ No

Have you received therapy in the past 12 months? ☐ Yes ☐

If yes, for what condition? _____

Do you have a pacemaker? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

Do you have a history of:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal Bleeding	☐	☐	Closed Head Injury	☐	☐	Gout	☐	☐	Multiple Sclerosis
☐	☐	Angina	☐	☐	Colitis	☐	☐	Heart Disease	☐	☐	MI/Heart Attack
☐	☐	Anxiety	☐	☐	Congestive Heart Failure	☐	☐	Hepatitis B	☐	☐	Osteoarthritis
☐	☐	Arrhythmia	☐	☐	COPD	☐	☐	Hepatitis C	☐	☐	Osteoporosis
☐	☐	Asthma	☐	☐	CVA (Stroke)	☐	☐	Hiatal Hernia	☐	☐	Psoriatic Arthritis
☐	☐	Bipolar Disorder	☐	☐	Degenerative Disc Disease	☐	☐	High Cholesterol	☐	☐	PVD
☐	☐	Blood Clotting Disorder	☐	☐	Depression	☐	☐	HIV/AIDS	☐	☐	Rheumatoid Arthritis
☐	☐	Bowel Incontinence	☐	☐	Diabetes Type I	☐	☐	High Blood Pressure	☐	☐	Scoliosis
☐	☐	Cancer	☐	☐	Diabetes Type II	☐	☐	Hypothyroidism	☐	☐	Seizure Disorder
☐	☐	Carpal Tunnel Syndrome	☐	☐	DVT	☐	☐	IBS	☐	☐	Shortness of Breath
☐	☐	Cellulitis	☐	☐	Fibromyalgia	☐	☐	Joint pain	☐	☐	Sleeping Disorder
☐	☐	Chronic Back Pain	☐	☐	Frequent UTI	☐	☐	Lymphedema	☐	☐	TB
☐	☐	Chronic Neck Pain	☐	☐	GERD	☐	☐	Migraine Headaches	☐	☐	Urinary Incontinence
☐	☐	Crohn's Disease	☐	☐	Glaucoma	☐	☐	MRSA			

Other conditions not listed: _____

_____

Please list current medications:

_____

_____

_____

LATEX allergy? ☐ Yes ☐ No

Please list any other allergies:

_____

_____

Type of home:

☐ Single Level Home ☐ Ground Floor Apartment ☐ Assisted Living Facility ☐ Other: _____

☐ 2 Level Home ☐ Upper Level Apartment ☐ Skilled Nursing Facility

Who does the patient live with?

☐ Spouse ☐ Parent(s) ☐ Alone

☐ Child(ren) ☐ Other Family Member ☐ Other: _____

Are others in home able to assist if needed? ☐ Yes ☐ No

Occupation: _____

Work Status: ☐ Employed Full Time ☐ Employed Part Time ☐ Not employed ☐ Full time student ☐ Part time student

☐ Retired ☐ Permanently Disabled

Does the patient currently smoke?

☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

If yes, how many packs per day? _____

Pain Assessment

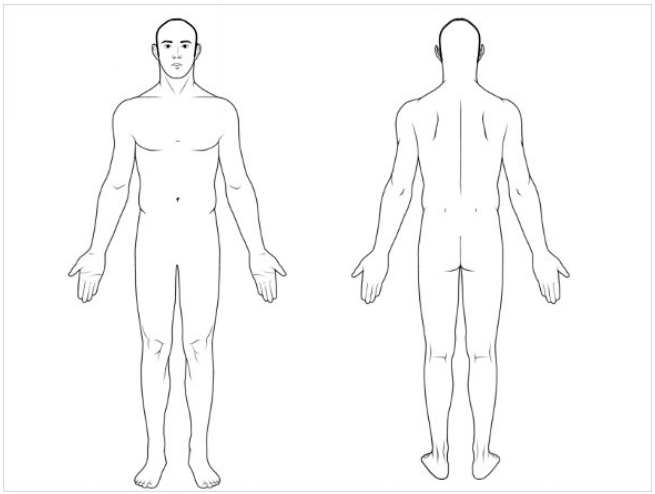
Rate your symptom intensity in the past 5 days:

(0 is no pain or symptoms and 10 is worst possible pain or symptoms)

Symptoms at worst: _____ out of 10

Symptoms at best: _____ out of 10

Please indicate on the body diagram below where you have pain:



PATIENT SIGNATURE: _____ **DATE:** _____