Grace Physical Therapy & Sports Rehab

PATIENT INTAKE FORM

Name: _____ Emergency Contact: _____

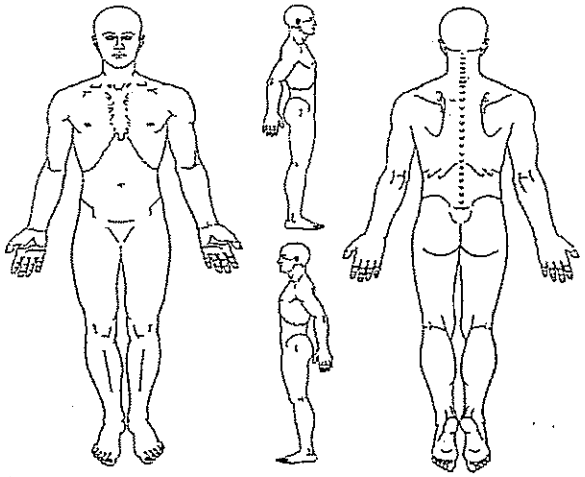
Referring Provider: _____ D.O.B: _____

Occupation: _____ Currently working: ( ) Yes ( ) No Email: _____

Have you attended Physical Therapy this year? ( ) Yes ( ) No Date of Onset/Injury: _____

Currently in Home Health? ( ) Yes ( ) No Motor Vehicle Accident: ( ) Yes ( ) No

Please mark the location of your symptoms using the key below:



X Pain ++ Numbness ---- Tingling

On a scale from 0-10, 0 being no pain, and 10 being the worst pain imaginable (within the past 2-4 weeks) please mark below:

_____ Now _____ Overall Best _____ Overall Worst

Circle which description(s) best describes your pain:

Sharp / Dull / Aching / Shooting

What makes your pain feel worse? _____

_____

What Decrease your pain? _____

Previous Surgeries? _____

History of X-Rays/MRIs? _____

Medications? _____

_____

Circle YES or NO to the following:

Do you have a pacemaker?	yes / no	Personal history of cancer?	yes/ no	Are you pregnant?	yes / no	Do you have high blood pressure?	yes/ no	Are you diabetic?	yes /no

Missed Appointment & Cancellation Policy:

Your appointment time is valuable and has been reserved specifically for you. If it is necessary to reschedule your appointment, please provide us with **24 hour notice**. Grace PT reserves the right to charge a **$25 cancellation or no show fee**. This fee is not covered by your insurance or workers compensation carrier.

Appoint reminder Consent: I give Grace PT permission to send automatic appointment reminders via text, email or phone calls. I give Grace PT permission to send me emails regarding clinic closures and customer satisfaction surveys.

Financial Agreement: Please read and sign below stating that you understand:

I understand it is my responsibility to be aware of my insurance benefits and notify Grace PT of any insurance and demographic changes.

I understand that it is Grace PT's policy to collect all co-pays/co-insurance/self-pay payments at time of service.

I authorize my insurance benefits to be paid directly to Grace Pt and agree that I am financially responsible for any amounts not covered and/or paid by them or legal representation. I understand if I do not pay the full amount, Grace PT may turn my account over to a collection agency if I do not respond to monthly statements and/or payment arrangements.

I, _____, herby consent to evaluation and/or treatment of my condition and pain/symptom complaints by a licensed physical therapist and/or physical therapy assistant employed by or under contract of Grace Physical Therapy & Sports Rehab.

Patient/Guardian Signature: _____ Date: _____