MADISON SPINE PHYSICAL THERAPY PATIENT DATA SHEET

DO NOT EMAIL The electronic form is provided for your convenience. With respect to responding to this form, please do not send via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

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

☐ Yes ☐ No

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

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:
MADISON SPINE 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: MADISON SPINE PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. Initials:_____

WAIVER AND RELEASE

I hereby release, discharge and acquit: MADISON SPINE 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: MADISON SPINE PHYSICAL THERAPY ambulance service, Emergency Medical Technician, physician or urgent care services. 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. **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 _____

Medical History Form

Patient Name:	**Today's Date:**	
Referring Physician:	**Date of Birth:**	**Age:**
Primary Care Physician:	**Are You Presently Working**? ☐ Yes ☐ No	
Date of Next Physician Appointment:	**Date of Injury or Onset:**	

Reason for Therapy:

Cause of Injury or Onset: ☐ Accident ☐ Auto ☐ Work ☐ Other: **If Other, please explain**:

Have you been hospitalized for the present condition? Yes ☐ No **If Yes, date**:

Did you have surgery for this condition? ☐ Yes ☐ No **If Yes, date**:
If Yes, surgery type:

Are you currently receiving any other care for the condition mentioned above? ☐Yes ☐No
If Yes, please describe:

Have you ever received therapy in the past for the condition mentioned above? ☐Yes ☐ No **If Yes, date:**
Describe previous treatment:

Previous Treatment: ☐Successful ☐Unsuccessful

Have you fallen in the last year? ☐ Yes ☐ No **If Yes, how many times?** **If Yes, were you injured?** ☐ Yes ☐ No
Do you feel unsteady when standing or walking? ☐ Yes ☐ No **Do you worry about falling?** ☐ Yes ☐ No

What are your personal goals/outcomes you hope to achieve from therapy?

Describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor **Do you smoke or use tobacco?** ☐ Yes ☐ No

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

☐ **Allergies** ☐ **Latex** ☐ **Other**	☐ **Dizziness**	☐ **Kidney Problems**
☐ **Anemia**	☐ **Epilepsy or Seizure Disorder**	☐ **Metal Implants**
☐ **Anxiety or Panic Disorders**	☐ **Fainting**	☐ **MRSA**
☐ **Arthritis** ☐ **OA** ☐ **RA**	☐ **Fatigue or Weakness**	☐ **Multiple Sclerosis**
☐ **Asthma**	☐ **Fever or Chills**	☐ **Nausea / Vomiting**
☐ **Blood Thinners**	☐ **Fractures**	☐ **Osteoporosis**
☐ **Bowel or Bladder Disorder**	☐ **Headaches**	☐ **Pacemaker**
☐ **Bleeding Disorder**	☐ **Head Injury or Concussion**	☐ **Parkinson's Disease**
☐ **Cancer**	☐ **Hearing Impairment**	☐ **Peripheral Vascular Disease**
☐ **Chronic Cough**	☐ **Heart Disease or Heart Attack**	☐ **Respiratory or Breathing Problems**
☐ **COPD**	☐ **Hepatitis** ☐ **A** ☐ **B** ☐ **C**	☐ **Ringing in Ears**
☐ **Congestive Heart Failure**	☐ **Hernia**	☐ **Sexual Dysfunction**
☐ **Currently Pregnant**	☐ **Blood Pressure** ☐ **High** ☐ **Low**	☐ **Skin Abnormalities**
☐ **Deep Vein Thrombosis (DVT)**	☐ **HIV or AIDS**	☐ **Stroke or TIA**
☐ **Depression**	☐ **Hypoglycemia**	☐ **Thyroid Problems**
☐ **Diabetes** ☐**Type I** ☐ **Type II**	☐ **Hypersensitivity to Hot or Cold**	☐ **Tuberculosis**

List any other medical problems and explain:

Over the Counter Medications (check all that apply): ☐ Aspirin/Ibuprofen ☐ Antacids ☐ Sleeping Aids ☐ Cold Medicine:
☐ Cough Medicine ☐ Allergy Relief ☐ Laxative ☐ Diet Pills ☐ Vitamins/Herbal Supplements ☐ Other:

Medical History Form

Medication List			
Name of Medication	**Dosage**	**Frequency**	**Route**
1			☐ Injection ☐ Oral ☐ Topical ☐Other
2			☐ Injection ☐ Oral ☐ Topical ☐Other
3			☐ Injection ☐ Oral ☐ Topical ☐Other
4			☐ Injection ☐ Oral ☐ Topical ☐Other
5			☐ Injection ☐ Oral ☐ Topical ☐Other
6			☐ Injection ☐ Oral ☐ Topical ☐Other
7.			☐ Injection ☐ Oral ☐ Topical ☐Other
8.			☐ Injection ☐ Oral ☐ Topical ☐Other
9.			☐ Injection ☐ Oral ☐ Topical ☐Other
10.			☐ Injection ☐ Oral ☐ Topical ☐Other
11.			☐ Injection ☐ Oral ☐ Topical ☐Other
12.			☐ Injection ☐ Oral ☐ Topical ☐Other

Signature of Patient:		
Printed Name of Patient:		**Date:**
For Staff Use Only		
Weight (lbs):	**BMI = Weight (lbs) / [Height (in) X Height (in)] X 703**	☐ WNL {BMI = ≥ 18.5 and < 25
Height (in):		☐ Above Normal Parameters [BMI ≥ 25
BMI:		☐ Below Normal Parameters [BMI < 18.5]
Signature of Therapist:		**Date:**

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