Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ **Date:** _____ (dd/mm/yr)

Insurance: _____

Date of Birth: _____ ☐ **male** ☐ **female**

Address: _____

_____

_____

Marital status

S	M	W	D	SEP

Phone #: home: _____ **work:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow

☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ____ Length of cycle: _____

Date - 1st day last period: _____

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? _____

How many children do you have? _____

Birth control method: _____

Date of last PAP test: _____

☐ normal, ☐ abnormal

Date of last mammogram: _____

☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

_____

How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

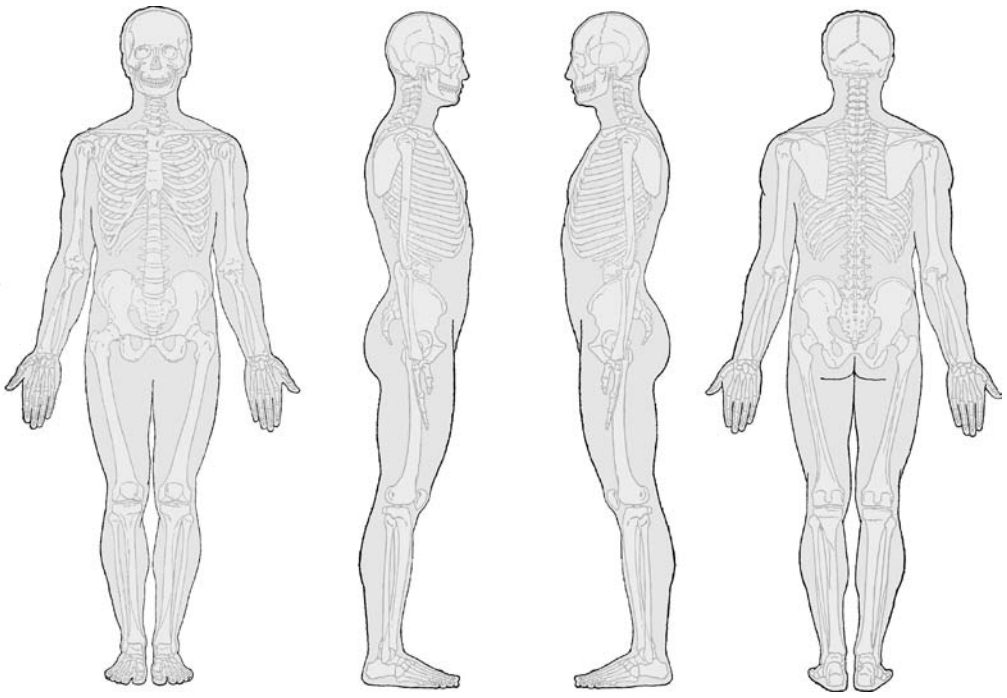
What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:

Worst Possible Pain

No Pain



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

Advanced Physical Therapy of Watertown, PLLC 26495 NYS Route 3 Watertown, NY 13601
Phone: (315) 782-0002 Fax: (315) 883-1333 www.APTOW.com

Registration Worksheet

Referring Doctor | Date Referred

Website FB TV Radio Word of Mouth Doctor Other ( )
How did you come to hear of us? (you may circle multiple choices)

Name | Date of Birth | Email Address

Address | City | State | Zip Code

Chief Complaint/Diagnosis | Home Phone | Cell Phone

Male Female | Single Married Divorced Student
Sex | Marital Status | Social Security Number

Place of Employment | Occupation | Work Phone

Insured/Sponsor Name | Place of Employment | Insured/Sponsor's Date of Birth

Address | City | State | Zip Code

Phone Number | Guarantor's Social Security Number

Notify in Case of Emergency | **Phone Number** | **Relationship**

Medicare Patient's Only – Had any PT and/or OT treatments in the current year? Y N PT OT

The APTOW Pain Catastrophizing Scale

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint pain or muscle pain.

Instructions: We are interested in the thoughts and feelings you have when you are in pain. Listed below are thirteen statements that may be associated with pain. Using the scale below, please choose the statement that best describes what you're feeling when you are experiencing pain.

RATINGS: 0. Not at all / 1. Slightly / 2. Moderately / 3. Greatly / 4. All the Time

When I'm in Pain...

Number	Statement	Rating
1	I worry all the time about whether the pain will end.	
2	I feel I can't go on.	
3	It's terrible. I think it's never going to get any better.	
4	It's awful. I feel that it overwhelms me.	
5	I can't stand it anymore.	
6	I become afraid the pain will get worse.	
7	I keep thinking of other painful events.	
8	I anxiously want the pain to go away.	
9	I can't seem to keep it out of my mind.	
10	I keep thinking about how much it hurts.	
11	I keep thinking about how badly I want the pain to stop.	
12	There is nothing I can do to reduce the intensity of the pain.	
13	I wonder whether something serious may happen.	

Name _____ **Date** _____

Thank you for participating in the APTOW Pain survey. Your participation will be kept strictly confidential. If you have any comments or questions about the survey, please let us know.

Must be completed per insurance regulations

Medication List Name: Date:

Medication-Herb Vitamin, etc.	Dosage	Method / Route	Frequency Taken	Purpose / Reason

Advanced Physical Therapy of Watertown PLLC

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called Health Connections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Health Connections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Health Connections website at http://healtheconnections.org/ .

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through Health Connections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through Health Connections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in Health Connections to access my electronic health information through Health Connections, I may do so by visiting Health Connections website at http://healtheconnections.org/ or calling Health Connections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Advanced Physical Therapy of Watertown, PLLC 26495 NYS Route 3 Watertown, NY 13601
Phone: (315) 782-0002 Fax: (315) 883-1333 www.APTOW.com

General Consent for Treatment, Financial Policy, Release of Records & Cancellation Policy

General Consent for Treatment

I, the patient _____ enter Advanced Physical Therapy of Watertown, PLLC clinic voluntarily for the purpose of diagnosis and medical treatment.

I am aware the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of diagnosis, treatment, test or examination performed at Advanced Physical Therapy of Watertown, PLLC.

Insurance Claims & Co-Payments

The patient must present an insurance card at each visit. **All co-payments and past due balances are due at time of check-in.** Insurance is a contract between you and your insurance company. You are responsible for all deductibles and co-insurance applied by your insurance. It is your responsibility to contact your insurance regarding coverage. You are responsible and liable for payment of all charges assessed for professional services rendered. If your insurance company has special requirements for your services such as limitation on the number of visits which can be performed or requirements for prior authorization, you must advise our office of the provisions or you may be responsible for additional charges. We make every attempt to minimize your out-of-pocket cost by following any provisions of which you make us aware.

If the responsible insurance company changes during course of treatment, patients must notify Advanced Physical Therapy of Watertown, PLLC immediately. Changes will take effect at the time of notification. Changes **CANNOT** be applied retroactively to previous dates of service.

Prior Authorizations

If your insurance company requires a prior authorization, you are responsible for obtaining it. Failure to obtain prior authorization may result in no payment from your insurance and the balance will be your responsibility.

Assignment of Benefits/Payment Guarantee

I assign and instruct my insurance company (s) to pay Advanced Physical Therapy of Watertown, PLLC directly for services. I request that payment of authorized benefits be made on my behalf. I understand that I am financially responsible for charges not covered by this assignment including collection costs. I understand if my insurance company forwards payment to me, I will endorse the check (s) within 48 hours. If payment is not forwarded and a collection attempt is made, I understand I will be financially responsible for all collection costs.

Returned Checks

The charge for a returned check is $30.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Outstanding Balance

It is our policy all past due accounts will be sent two statements. In the event an account is sent to collection, the person financially responsible for the account will be responsible for all collection costs, including attorney fees and court costs.

Authorization for Release of Information

The clinic may disclose all or part of the patient's record to any person or corporation which is or may be liable under contract to the clinic for all or part of the clinic's charges, including but not limited to hospital or medical services companies, billing and insurance companies, workers' compensation carriers, welfare funds or the patient's employer. The clinic may disclose my Social Security number to any State or Federal government agencies, as required by law.

Medical Records Fee

Advanced Physical Therapy of Watertown, PLLC will provide medical records to a referred provider as a courtesy. Any other requests will require prepayment of $.75 per copied page. This fee is subject to change without notice at any time.

Joint Notice of Privacy Practices
I have acknowledged I have received a copy of the Advanced Physical Therapy of Watertown, PLLC Joint Notice of Privacy Practices.

Release of Liability
I agree the clinic shall not be liable for loss or damage to any personal property.

Cancellation Policy
We strive to provide our patients with the utmost professionalism and excellence of care. Our commitment to your well-being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

You are coming to therapy to remedy the condition which is affecting you; therefore it is absolutely necessary you attend all of your scheduled appointments. If you are unable to keep an appointment, please contact our office during business hours at least 24 hours in advance. The clinic does have an answering machine for you to leave a message if you must call after business hours.

If you expect to be arriving more than 10 minutes late, please call ahead to confirm you are still able to be seen for your appointment.

Any patient arriving more than 15 minutes late without contacting the office will not be able to be accommodated for their session.

Any patient who has missed two appointments and the therapist believes this may compromise treatment effectiveness, the patient may be discharged. At which time your provider will be notified your services has been discontinued due to non-compliance.

We do not "double book" appointments for our patients. Your appointment time is specifically for you. If you are unable to come to your appointment, please call us in advance. **If you do not call 24 hours in advance you will be charged a $50.00 cancellation/no show fee. This fee is not a covered service by your insurance and you will be financially responsible for this each time it occurs.**

We realize your time is valuable and every attempt is made by the staff to keep on time. However, please understand that unforeseen circumstances do occasionally arise during treatment time. Please accept our apology in advance for any additional wait time beyond your scheduled appointment time and understand you will receive the same careful consideration during your treatment session. We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

_____ _____
Patient/Parent/Guardian Date

_____ _____
APTOW Representative Witness Date