PATIENT INTAKE FORM

Patient Information

DOB: / /	Age:	Gender: M / F	Marital Status: M S D W Other

First Name	Middle	Last Name	SSN

Street Address	City	State	Zip

Home Phone ( ) -	Cell Phone ( ) -	Work Phone ( ) -

Preferred Number: Home/Cell/Work	May we leave a message?
Employer:	Employer Address:
Email:	

Insurance Information – Do not fill out if we have received a copy of your insurance card(s)

Insurance/Payment Method: Self-Pay, Commercial, Medicare			
Name of Insurance Company:	ID / Policy #:	Group #	Insurance Phone #
Policy Holder's Name:	Policy Holder's SS#	Policy Holder's DOB: / /	
Policy Holder's Relationship to patient:	Policy Holder's Employer:		

Miscellaneous Information

Surgery? Yes/No Surgical type:	Surgeon Name:	Date of Surgery/ Injury:
Auto Accident? Yes/No	Date of Accident:	Auto Insurance Company:
Is there an attorney involved?	If yes, Attorney's Name:	Attorney's Phone ( ) -

Emergency Contact Information

Emergency Contact Name:	Phone: ( ) -

Consent Form

Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Ellard Physical Therapy, LLC. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Assignment of Benefits and Insurance Proceeds

I authorize payment of medical benefits to Ellard Physical Therapy for services rendered. Ellard Physical Therapy, LLC will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

Insurance: We will gladly bill and accept payment from your health insurance plan. Your copayment is expected at the time of service. We accept cash, checks, and major credit cards. Any amounts not covered by your insurance carrier including co-insurance and deductible is your responsibility.

In the event that you do not pay any outstanding balance and your account becomes delinquent, you will be sent to the collections company. Any account sent to collections is subject to 30% fee of the principal balance.

Patient Information Consent Form (HIPAA)

I have read and fully understand Ellard Physical Therapy, LLC Notice of Information Practices. I understand that Ellard Physical Therapy, LLC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Ellard Physical Therapy, LLC will consider requests for restrictions on a case by case basis but is not required to oblige to such requests.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Ellard Physical Therapy, LLC Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Ellard Physical Therapy, LLC has 30 days to respond to my request.

Release of Information

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

I have read and understand the above consents, assignment of benefits, release of information above.

Patient Printed Name: ______________________________

Patient Signature: ______________________________ **Date:** ____/_____/____

Dry Needle Consent Form

Dry needling involves inserting a tiny monofilament needle in a muscle(s) to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension and will promote healing. This is not traditional Chinese acupuncture, instead it is a medical treatment that relies on a medical diagnosis to be effective. Dry needling is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

BENEFITS:

- Decreased pain both locally and into referral sites
- Improved muscled function (able to contract and relax appropriately)
- Improved ability to move and function for daily activities • Decreased muscular tension and improved myofascial flexibility

RISKS:

- Muscle soreness or bruising at/near needling site, which may last 1.5 hours to 2 days
- Pneumothorax if needling around/near chest wall - extra precautions always taken in these areas
- Minor bleeding or bruising from superficial blood vessels

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Please answer the following questions:

1. Have you ever fainted or experienced a seizure? ☐ Yes ☐ No
2. Do you have a pacemaker or any other electrical implants? ☐ Yes ☐ No
3. Are you currently taking anticoagulants (ex: Aspirin, blood thinners)? ☐ Yes ☐ No
4. Are you currently taking antibiotics for an infection? ☐ Yes ☐ No
5. Do you have a damaged heart valve, metal, or other risk of infection? ☐ Yes ☐ No
6. Are you pregnant? ☐ Yes ☐ No
7. Do you suffer from metal allergies? ☐ Yes ☐ No
8. Are you a diabetic or do you suffer from impaired wound healing? ☐ Yes ☐ No
9. Do you have Hepatitis B, C, HIV, or any other infectious disease? ☐ Yes ☐ No

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

You have the right to withdraw consent for this procedure at any time before it is performed.

______________________________ ______________

Patient or Authorized Representative **Date**

Physical Therapist Affirmation: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof and has consented to its performance.

Medical History

Patient:

Today's Date:

General Information

1. Is this injury related to? ☐ Work ☐ Car Accident ☐ Other Liability/Potential Lawsuit ☐ Not Applicable

2. Do you have a Primary Care Physician / Family Doctor? ☐ No ☐ Yes
   If yes, have you had an appointment with him / her in the last 12 months? ☐ No ☐ Yes

3. Race/Ethnicity (Please select one):

☐ Caucasian (White) ☐ Hispanic or Latino Origin ☐ Eskimo/Inuit
☐ African American ☐ Asian ☐ Native American
☐ Other ☐ Declined

Please Mark One Box For Each Item	No	Yes Under a Year	Yes Over a Year	No Answer / Invalid	Please Mark One Box For Each Item	No	Yes Under a Year	Yes Over a Year	No Answer / Invalid
Smoking (including smokeless tobacco)	☐	☐	☐	☐	Sexual dysfunction	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Bladder / bowel problems	☐	☐	☐	☐
Heart condition	☐	☐	☐	☐	Groin numbness	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	Arthritis	☐	☐	☐	☐
Chest pain	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	Psychological condition	☐	☐	☐	☐
Kidney condition	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
Blood clot / DVT	☐	☐	☐	☐	Dizziness / faintness	☐	☐	☐	☐
Breathing difficulties / asthma	☐	☐	☐	☐	Ringing in ears	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Allergy to latex (gloves)	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	Other allergy	☐	☐	☐	☐
Circulation / vascular problems	☐	☐	☐	☐	Head injury	☐	☐	☐	☐
Peripheral neuropathy	☐	☐	☐	☐	Obesity	☐	☐	☐	☐
Unexplained weight loss	☐	☐	☐	☐	Chronic pain / fibro / headaches	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	Fractures	☐	☐	☐	☐
Night sweats / night pain	☐	☐	☐	☐	Infection	☐	☐	☐	☐
Metal Implants	☐	☐	☐	☐	Fever / nausea	☐	☐	☐	☐
Pacemaker	☐	☐	☐	☐	Are you pregnant?	☐	☐	☐	☐

	No	Yes	If yes, please specify the condition
Infection Disease	☐	☐	
Neurologic Condition (MS / Parkinson's)	☐	☐	
Pediatric Developmental Condition	☐	☐	
Skin Disease	☐	☐	
Spinal Cord Injury	☐	☐	
Degenerative Joint Disease	☐	☐	☐ Spine ☐ Upper Extremity ☐ Lower Extremity

Medical History

Patient: **Today's Date:**

Patient Medication List

Please list ALL medications (including prescription, over-the-counter, vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

Medication	Dosage	Frequency	Route of Administration