PATIENT DATA SHEET

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

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

Mailing Address: _____

_____

_____

Physical Address: _____

_____

_____

_____

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

☐ Home: _____ _____

☐ Work: _____ _____

☐ Cell: _____ _____

SSN:

Email: _____

Would you like to be contacted by email? ☐ Yes ☐ No

Preferred language:

Intepreter required? ☐

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

Student Status: ☐ **Full-Time** ☐ **Part-Time** ☐ **None**

Date of Injury: _____ **Referring Physicain:** _____

Injury Area: _____

Auto or Work Accident: _____

EMPLOYMENT STATUS

Employment Status:
☐ **Active Military** ☐ **Full-Time** ☐ **None** ☐ **Part-Time** ☐ **Retired** ☐ **Self Employed**

PATIENT EMPLOYER INFORMATION

Employer: Occupation:

Address:

Phone:

SPOUSE EMPLOYER INFORMATION

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:

Are you receiving or have you received Home Health Services? ☐ Yes ☐ No

Are you receiving or have you received other therapy services? ☐ Yes ☐ No

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 down below.

CONTACTS

Name	Phone	Work	Cell	Fax	Type

_____ _____

Signature of Patient **Date**

PATIENT INTAKE AND CONSENT FORM

Please Initial Each as Applicable:

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

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:

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. _____

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. _____

LIABILITY

I know and agree that:

is not responsible for loss or damage to personal valuables. _____

WAIVER AND RELEASE

I hereby release, discharge and acquit:

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. _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to:

I also authorize release of any medical records necessary to facilitate my treatment to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. 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. _____

NOTICE OF PRIVACY

I acknowledge receipt of Notice of Privacy Practices. _____

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

Patient/Guardian Signature_____ Witness Signature _____

CORNERSTONE *Physical Therapy*

MEDICAL HISTORY FORM

PATIENT NAME: _____ DATE OF BIRTH_____

REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____

PRIMARY CARE PHYSICIAN'S NAME: _____ ARE YOU PRESENTLY WORKING? Y N
CAUSE OF INJURY OR ONSET: _____ DATE OF NEXT MD APPT: _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?
1. _____
2. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?
1. _____
2. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR
DO YOU USE TOBACCO? (circle one) YES NO IF YES, HOW MUCH? _____

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO
IF YES, WHEN AND
WHY_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one)YES NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?: _____

CURRENT MEDICATIONS: _____
_____

ALLERGIES: Medication _____Reaction_____ Other _____Reaction_____

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction_____

WEAR GLASSES / CONTACTS?: YES NO

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE:_____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: _____
IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? Y N
IF YES, WHAT SYMPTOMS: _____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- ▫ ANEMIA
- ▫ ARTHRITIS
- ▫ CANCER
- ▫ CARDIOVASCULAR PROBLEMS
- ▫ HOLTER MONITOR - currently wearing?
- ▫ PACEMAKER
- ▫ HIGH BLOOD PRESSURE ▫ controlled ▫ uncontrolled
- ▫ LOW BLOOD PRESSURE
- ▫ CURRENTLY PREGNANT
- ▫ DIABETES ▫controlled ▫uncontrolled
- ▫ DEPRESSION
- ▫ DIZZINESS/FAINTING
- ▫ FRACTURES
- ▫ HEADACHES
- ▫ HEPATITIS/HIV
- ▫ MRSA (Methicillin Resistant Staphylococcus Aureus)
- ▫ OSTEOPOROSIS
- ▫ RESPIRATORY PROBLEMS
- ▫ ASTHMA ▫ controlled ▫ uncontrolled
- ▫ COPD ▫ controlled ▫ uncontrolled
- ▫ Other
- ▫ SEIZURES ▫ controlled ▫ uncontrolled
- ▫ THYROID PROBLEMS
- ▫ KIDNEY PROBLEMS

If checked any above, explain: _____
▫ **ANY OTHER MEDICAL PROBLEMS:** _____

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR/INS YEAR? YES / NO HOW MANY

HAVE YOU HAD PRIOR CHRIOPRACTOR SERVICE THIS CALENDAR/INS YEAR. YES / NO HOW MANY

WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH HOW MANY

Pain Level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

PATIENT: _____ Date_____ REVIEWED BY Therapist: _____Date_____

CORNERSTONE *Physical Therapy*

Cancellation No Show Policy

At Cornerstone Physical Therapy, our goal is to make our clinic accessible to as many patients as possible. Because our services are in high demand, we maintain a full schedule. This allows us to provide each patient with the individual attention necessary for the highest quality care.

When a patient cancels shortly before an appointment or is a "no-show," we miss the opportunity to treat another patient. We appreciate your courtesy in calling us as soon as possible if you must cancel you scheduled appointment. Your time slot then has a better chance of being reassigned to another patient.

In the event you do not notify us within 24 hours of you appointment time to cancel your appointment you will be charged $50.00
This charge is not billed to your insurance company you will be responsible for the Cancellation Fee.

Exceptions:
We understand those emergencies or other circumstances beyond your control that may require you to be late or miss an appointment. If so, please let us know as soon as possible. We may consider exceptions on a case by case basis. We appreciate your understanding and cooperation.

Discharge:
If you have 3 cancels or no-shows and are non-compliant you may be discharged from our care. If you are feeling better and are not in need of Physical Therapy please let us know so we can forward a note to your physician or surgeon.

_____ _____

Patient Name Date