NEW PATIENT INTAKE FORM

How did you FIRST hear about our office: ________________________________

PATIENT INFORMATION

First Name Middle Initial Last Name Preferred Name			Social Security Number
Address:	City:	State:	Zip Code:
Home Phone: Cell Phone:	Date of Birth (mm-dd-yyyy)	Sex: M F	Status: Single Married Divorced Separated Widowed Unknown
Date of Injury/Onset Date	Auto Accident Yes-State ___ No	Work Related: Yes No	

PRIMARY INSURANCE

Name of Insurance Company:	**Policy or Claim Number**	**Group #**
Policy Holder Name:	**Date of Birth:**	**Social Security Number:**
Policy Holder Employer:	**Policy Holder's Work Phone:**	**Patient Relationship to Policy Holder** **Self Spouse Dependent Other**

WORKER'S COMPENSATION

Adjuster Name:	Adjuster Phone #:	Case Number:
Name of Employer:	Employer Phone: Contact Person:	Date of Injury: Body Part Injured:

PATIENT EMPLOYER INFORMATION

Employer Name:	Employer Phone:	**Employment Status:** None FT PT Self-Emp Retired Student	
Address:	City:	State:	Zip Code:

EMERGENCY CONTACT INFORMATION

Contact Name: Can We Speak to this Person? Yes No	Home Phone: Cell Phone:	Relationship Spouse Mother/Father Relative Friend

PHYSICIAN INFORMATION

Name of Referring Physician:	Telephone #	
Name of Primary Care Physician:	Telephone #	

FINANCIAL INFORMATION

Thank you for choosing Peak Rehabilitation for your physical therapy and rehabilitative needs. The services you have elected to participate imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

We expect payment at the time of service of any deductible, co-payment/co-insurance as determined by your contract with your insurance carrier. Many insurance companies have stipulations that may affect your coverage. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue therapy past your approved period, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to Peak Rehabilitation. I authorize my insurer to pay any benefits directly to Peak Rehabilitation. I agree to pay Peak Rehabilitation the full and entire amount of all bills incurred by me or my dependant, and if applicable, any amount due after payment has been made by my insurance carrier.

Signature: ____ **Date:** ____

CONSENT FOR TREATMENT, AUTHORIZATION TO RELEASE INFORMATION, & ASSIGNMENT OF BENEFITS

I hereby authorize Peak Rehabilitation through its appropriate personnel, to perform or have performed upon me or dependant, assessment and treatment procedures relating to the diagnosis stated by my referring physician.

I hereby authorize Peak Rehabilitation to release to the appropriate agencies, any information acquired in the course of my or my dependant's examination and treatment.

I further authorize Peak Rehabilitation to submit my insurance claims for health benefit and submit any appeal that may be necessary when a denial of benefits is issued.

Signature: ____ **Date:** ____

HIPPA PRIVACY NOTICE

I have read and understand the Privacy Notice for Peak Rehabilitation, Inc.

Signature: ____ **Date:** ____

Peak Rehabilitation INC
Achieving Peak Function One Patient At A Time

PAST MEDICAL HISTORY FORM

Patient Name ______________________________ **Date:** __________________________________

Describe your current symptoms: ____

Have you had these symptoms before? Yes No

Check all that apply to your symptoms:

Work related injury	Recurrence of previous injury	Injury related to fall
Motor vehicle accident	Injury related to lifting	Other: ________________
Unknown cause of injury	Athletic/recreational injury	

Do you have a related surgery to above injury? Yes No

Do you have, or have had any of the following conditions?

	Yes	No		Yes	No
Diabetes			Allergy to Aspirin		
Chest Pain/Angina			Allergy to heat		
Heart disease			Allergy/poor tolerance cold		
Heart attack			Other allergies __________		
Heart palpitations			Hernia		
Pacemaker			Seizures		
Headaches			Metal Implants		
Kidney problems			Dizziness/Fainting		
Are you pregnant?			Recent Fractures		
Cancer			Surgeries		
Osteoporosis			Skin Abnormalities		
Bowel/Bladder abnormalities			Sexual Dysfunction		
Urine Leakage			Nausea/vomiting		
Asthma/Breathing difficulties			Ringing in your ears		
Liver/Gallbladder problems			Rheumatoid Arthritis		
Smoking			Special diet guidelines		
Other __________________			Stroke/CVA		

If you answered YES to any of the above, please explain briefly and give approximate date:

____

____

____

Is there any other information regarding your past medical history that we should know about?

____

____

Are you presently taking Medication? Yes No

Please list and explain for what condition ____

____

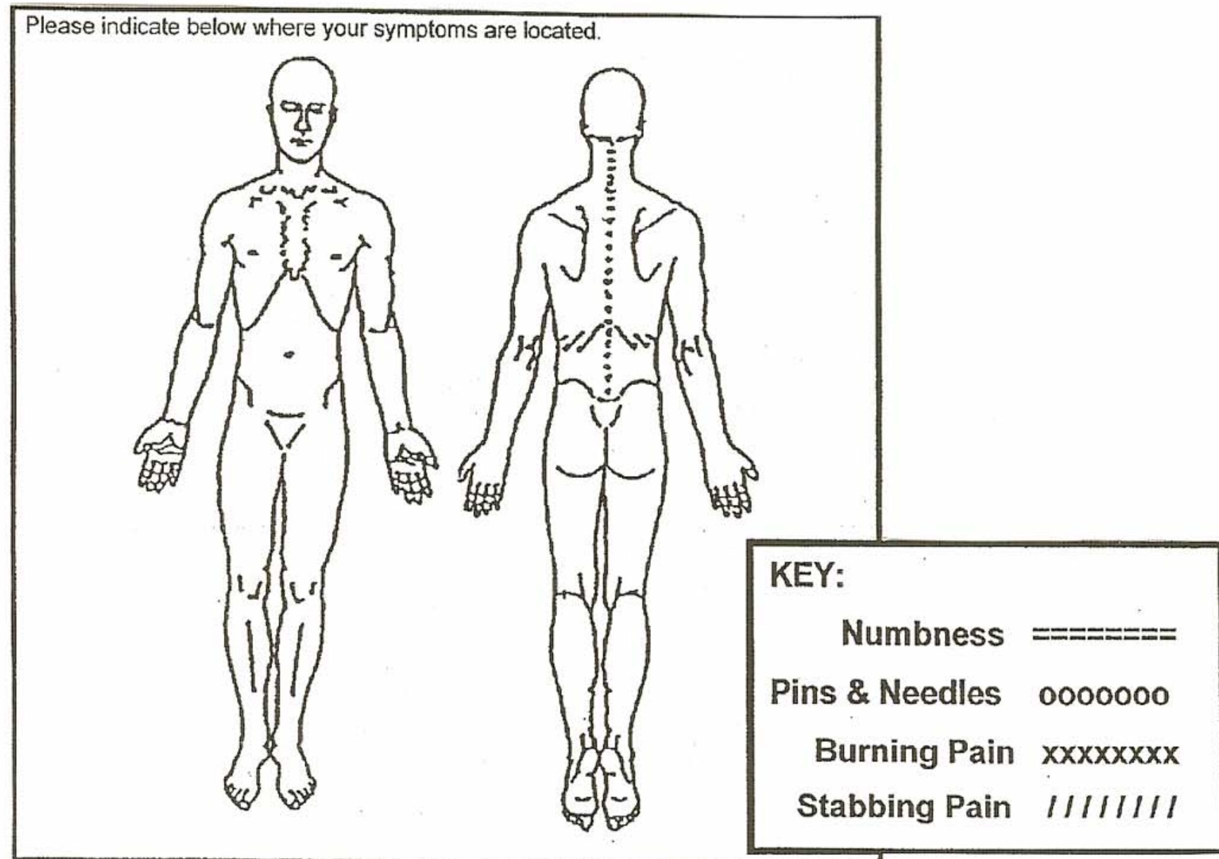
____

In the rare instance of an emergency who should we contact?

Name: ______________________________ Phone Number: ____________________

Do you participate in any sports, exercise program, or activities on a regular basis? ☐ Yes ☐ No

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: ____________



______________________________ __________ ______________________________ __________

Patient's Signature Date Guardian Signature if patient is a minor Date

______________________________ __________

Therapist Signature Date