IRG

PHYSICAL THERAPY | HAND THERAPY

YOUR BEST SELF

PATIENT INTAKE FORM

PATIENT INFORMATION

First Name ________________________ MI _____ Last Name ______________________________ DOB ___/___/_____

Address _____________________________ Apt#______ City ________________________ State _____ Zip ___________

Cell Phone (______) _______-____________ Alternate Phone (______) _______-____________ ❑ Male ❑ Female

Please indicate if we have permission to leave a detailed voicemail or text message if we are unable to reach you in person: Voicemail: ❑ Yes ❑ No Text Message: ❑ Yes ❑ No

Email Address ____ *(IRG will not share, sell or trade your information)*

Referring Provider __________________________ PCP _________________________ Last MD Visit ___/___/_____

Who can we thank for your referral? ❑ Doctor ❑ Friend/Family ❑ Website/Social Media ❑ ATC/Coach ❑ Community Event/Presentation ❑ Radio/TV ❑ Flyer/Postcard Other: ____________________________

If patient is under 18, name of parent/guardian completing and signing intake paperwork:
Name: ________________________________ Relationship ___________________ Phone (______) _______-____________

In case of an emergency, please contact:
Name: ________________________________ Relationship ___________________ Phone (______) _______-____________

MEDICAL INSURANCE INFORMATION

Financial Policy and an estimate of benefits will be given at check-in. CLICK TO VIEW FINANCIAL POLICY

Primary Insurance: ______________________________ Secondary Insurance: ______________________________

Did your injury or condition occur at work or as a result of a motor vehicle accident? ❑ Yes ❑ No
If Yes: ❑ L&I/Workers Comp ❑ Motor Vehicle Accident Date of Injury ____/____/________

HIPAA PRIVACY NOTICE

Please check one:

CLICK TO VIEW HIPAA NOTICE

❑ I acknowledge receipt of a copy of the Notice of Privacy Practices

❑ I have been offered a copy of the Notice of Privacy Practices, but I have chosen to decline a copy at this time

Please include the names of persons with whom we are allowed to discuss your condition and/or billing information with:

Name: ________________________________ Relationship ___________________

Name: ________________________________ Relationship ___________________

Name: ________________________________ Relationship ___________________

CONSENT TO TREATMENT / ASSIGNMENT OF BENEFITS

By signing below:

- I hereby consent to evaluation and treatment (or the evaluation and treatment of my dependent) at Integrated Rehabilitation Group (IRG) & Affiliates.
- I authorize all available medical insurance benefits be directly assigned to Integrated Rehabilitation Group (IRG) & Affiliates for services rendered.
- I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original.

Signature ____ Date ___________________

(Parent or Guardian signature if patient is a minor)

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MEDICAL QUESTIONNAIRE

GENERAL INFORMATION

Name ______________________________ DOB ___/___/_____ Age __________

Date of Injury or Onset of Symptoms: ___/___/_____ Date of Surgery (if applicable): ___/___/_____

Employer: ______________________________ Occupation: ______________________________

Where did your injury occur? ❑ Work ❑ Auto/MVA ❑ Home ❑ Other: ______________________________

Side of Injury: ❑ Right ❑ Left ❑ Bilateral

Briefly describe how your injury occurred: ______________________________

Briefly describe your present symptoms: ______________________________

Does your pain level change over the course of day and night?: ______________________________

Have you had any of the following treatment and/or tests for this condition? *(check all that apply)*

❑ Physical Therapy ❑ Occupational Therapy ❑ Chiropractic ❑ Massage ❑ Home Health ❑ Acupuncture

❑ Hospitalization ❑ X-Rays ❑ MRI ❑ CT Scan ❑ Bone Scan ❑ Injections ❑ Other: ____________

Please list the names of practitioners you have seen for this condition:______________________________

____

What do you hope to accomplish with therapy? *(your personal goals):* ______________________________

____

MEDICAL HISTORY *(check all that apply)*

❑ Allergies: ______________________________

❑ Anxiety

❑ Asthma

❑ Arthritis

❑ Blood Clots

❑ Bruise Easily

❑ Cancer: ______________________________

❑ **Other:** ______________________________

❑ Depression

❑ Diabetes

❑ Dizziness/Vertigo

❑ Fibromyalgia

❑ Fractures

❑ Heart Disease

❑ Hepatitis

❑ High Blood Pressure

❑ High Cholesterol

❑ HIV/AIDS

❑ Hypoglycemia

❑ Kidney Problems

❑ MRSA

❑ Multiple Sclerosis

❑ Osteoporosis

❑ Seizures

❑ Sensitivity to heat or ice

❑ Stroke

❑ Traumatic Injury

❑ **No Significant Medical History**

OTHER MEDICAL INFORMATION

Height: _________ Weight:_________ Do you have a pacemaker? ❑ Yes ❑ No Are you pregnant? ❑ Yes ❑ No

Do you smoke tobacco? ❑ Yes ❑ No If yes, how much__________________ how long _____________

Do you drink alcohol? ❑ Yes ❑ No If yes, how much______________________________

How would you rate your overall health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you exercise outside of normal daily activities? ❑ Yes ❑ No

List any surgeries/major accidents/illnesses with dates: ______________________________

____

List all current medications *(or provide front desk with a list that can be copied into your medical record)*: ____________

____

Signature ______________________________ Date ____________________

(Parent or Guardian signature if patient is a minor)