PATIENT INTAKE FORM

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NAME DATE

EMAIL ADDRESS

BIRTHDATE AGE GENDER PHONE NUMBER

STREET ADDRESS APT #

CITY STATE ZIP CODE

OCCUPATION EMPLOYER

EMERGENCY CONTACT RELATIONSHIP PHONE NUMBER

REASON FOR CONSULT (CHECK ALL THAT APPLY)

- ☐ PAIN/SORENESS
- ☐ SURGERY
- ☐ OPTIMIZING HEALTH & PERFORMANCE
- ☐ SPORTS INJURY
- ☐ HOME INJURY
- ☐ WORK INJURY
- ☐ BALANCE/FALL PREVENTION
- ☐ AUTO ACCIDENT
- ☐ SPORTS MASSAGE/SOFT TISSUE
- ☐ SPORTS PROGRAMMING
- ☐ WORKOUT PROGRAMMING
- ☐ NUTRITION CONSULT

IN YOUR OWN WORDS, DESCRIBE WHAT BRINGS YOU TO BELL PHYSICAL THERAPY.

_____

DATE OF ONSET: _____ HAVE YOU HAD AN X-RAY, MRI, OR CT? ☐ YES ☐ NO

IF YES, WHAT WERE THE RESULTS?

_____

DESCRIBE YOUR ISSUE. (CHECK ALL THAT APPLY)

- ☐ DEEP
- ☐ DULL
- ☐ ACHY
- ☐ STABBING
- ☐ BURNING
- ☐ SUPERFICIAL
- ☐ SHARP
- ☐ THROBBING
- ☐ SHOOTING
- ☐ PIERCING
- ☐ NUMBNESS
- ☐ TINGLING
- ☐ WEAKNESS
- ☐ TIGHTNESS OR RANGE OF MOTION LIMITATIONS

WHAT % OF THE DAY DO YOU HAVE PAIN?

☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

HAVE YOU HAD THIS PROBLEM IN THE PAST? ☐ YES ☐ NO

IF YES, IS IT THE SAME, WORSE, OR BETTER THAN BEFORE?

☐ SAME ☐ WORSE ☐ BETTER

DOES IT DISTURB YOUR REGULAR ACTIVITIES OR SLEEP? ☐ YES ☐ NO

IF YES, HOW?

WHEN DO YOU FEEL YOUR BEST? ☐ MORNING ☐ AFTERNOON ☐ EVENING

WHEN DO YOU FEEL YOUR WORST? ☐ MORNING ☐ AFTERNOON ☐ EVENING

PLEASE LIST ANYTHING THAT MAKES YOUR CONDITION BETTER.

PLEASE LIST ANYTHING THAT MAKES YOUR CONDITION WORSE.

WHAT IS THE SEVERITY OF YOUR PAIN (0 = NONE, 10 = WORST PAIN IMAGINABLE)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

WHAT ABOUT AT THE TIME OF YOUR INJURY?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

HAVE YOU SEEN ANYONE ELSE FOR THIS CONDITION? ☐ YES ☐ NO

WHAT IS THEIR PROFESSION? ☐ MD ☐ PT ☐ CHIRO ☐ OTHER

HAVE YOU RECEIVED ANY PREVIOUS TREATMENT FOR THIS CONDITION?

☐ YES ☐ NO

IF YES, PLEASE EXPLAIN.

WHAT DIAGNOSIS WAS MADE?_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS, OR SUPPLEMENTS? PLEASE LIST ALL PRESCRIPTIONS AND OVER-THE-COUNTER MEDICATIONS.

DO YOU HAVE ANY ALLERGIES? ☐ YES ☐ NO

IF YES, TO WHAT? _____

WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY?

THE ITEMS BELOW MAY RELATE TO YOUR CURRENT CONDITION. PLEASE CHECK THE BOX IF YOU CURRENTLY, OR HAVE EVER HAD ANY OF THESE SYMPTOMS.

GENERAL

- ☐ ABNORMAL WEIGHT LOSS/GAIN
- ☐ ADHD
- ☐ ALCOHOLISM/SUBSTANCE ABUSE
- ☐ ALLERGIES
- ☐ BLOOD/BLEEDING PROBLEMS
- ☐ BREAST LUMPS/SORENESS
- ☐ CANCER
- ☐ DEPRESSION/ANXIETY
- ☐ DEAFNESS/HEARING DIFFICULTY
- ☐ DIABETES
- ☐ FEVER/CHILLS WITHOUT THE FLU
- ☐ GENERAL FATIGUE
- ☐ NIGHT PAIN
- ☐ POOR SLEEP
- ☐ THYROID DISEASE
- ☐ VISION DIFFICULTIES

GASTROINTESTINAL

- ☐ ABDOMINAL PAIN
- ☐ APPENDICITIS
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ GALLBLADDER PROBLEMS
- ☐ HERNIA
- ☐ LIVER PROBLEMS/JAUNDICE
- ☐ FREQUENT NAUSEA/VOMITING
- ☐ PAIN OVER ABDOMEN
- ☐ POOR APPETITE
- ☐ POOR DIGESTION
- ☐ ULCER/HEARTBURN

SKIN

- ☐ BRUISING EASILY
- ☐ ITCHING/ECZEMA/RASH
- ☐ SKIN CANCER

CARDIO-RESPIRATORY

- ☐ ANKLE SWELLING
- ☐ ASTHMA/WHEEZING
- ☐ CHEST PAINS
- ☐ CHRONIC COUGH
- ☐ DIFFICULTY BREATHING
- ☐ EMPHYSEMA
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ IRREGULAR HEARTBEAT
- ☐ PREVIOUS HEART TROUBLE
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ VARICOSE VEINS
- ☐ BLOOD CLOTS/EMBOLI
- ☐ PACEMAKER

NEUROLOGICAL

- ☐ CONCUSSIONS
- ☐ CONVULSIONS
- ☐ DIZZINESS
- ☐ EPILEPSY/SEIZURES
- ☐ FAINTING
- ☐ HEADACHE
- ☐ MENTAL DISORDER
- ☐ NUMBNESS/TINGLING/WEAKNESS
- ☐ TWITCHING/TREMORS

MUSCULOSKELETAL

- ☐ LOW BACK PAIN
- ☐ NECK PAIN
- ☐ PAIN BETWEEN SHOULDERS
- ☐ HIP/KNEE/ANKLE/FOOT PAIN
- ☐ OSTEOPOROSIS
- ☐ TMJ ISSUES
- ☐ SHOULDER/ELBOW/WRIST/HAND PAIN
- ☐ SCOLIOSIS

HAVE YOU HAD ANY INJURIES IN THE PAST? ☐ YES ☐ NO

HAVE YOU HAD ANY SURGERIES OR HOSPITALIZATIONS? ☐ YES ☐ NO

FEMALES: ARE YOU PREGNANT OR NURSING? ☐ YES ☐ NO

FEMALES: DO YOU EXPERIENCE AN **IRREGULAR** MENSTRUAL CYCLE? ☐ YES ☐ NO

IF YES, WHEN WAS YOUR LAST PERIOD? _____

HAVE YOU EVER BEEN DIAGNOSED WITH AN EATING DISORDER? ☐ YES ☐ NO

IF YES, WHICH ONE? _____

I have completed this form to the best of my ability and discussed the information with Dr. Sam Bell. I understand that Dr. Bell is relying upon this information to make treatment recommendations.

_____ _____

Patient Signature (or parent/guardian if patient is under the age of 18) Date

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, disability or sexual orientation.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them. Response to physical therapy intervention varies from person to person; hence, it is not possible to predict your response to a specific modality, procedure, or exercise protocol. Bell Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain, injury, or other symptoms.
It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned and to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. If I am a parent, I give Bell Physical Therapy consent to treat my child.

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian signature, if patient is under the age of 18) Date

HIPAA PRIVACY ACT ACCEPTANCE & PAYMENT CONSENT FORM

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I consent to the use or disclosure of my protected health information (PHI) by Bell Physical Therapy for the purpose of treatment, payment, and health care operations. By signing this agreement, I verify I have read the Health Insurance Portability and Accountability Act (HIPAA) and am aware of my rights as a patient at Bell Physical Therapy. If you wish to obtain a copy of the HIPAA Privacy Act for your own records, it can be found at: https://www.hhs.gov/sites/default/files/privacysummary.pdf

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian signature, if patient is under the age of 18) Date

I agree to be responsible for full payment of my bill due to Bell Physical Therapy. I understand that Bell Physical Therapy accepts payment in the form of credit card, check, cash, or digital payments using the platforms Zelle, and Venmo. All payments shall be received within 1 week of services provided.

If a session is canceled by the patient less than 24 hours prior to the scheduled treatment time, the patient will be charged a 25$ cancelation fee.

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian signature, if patient is under the age of 18) Date