

# Hands On Physical Therapy of Mentor, LLC

## Patient Intake Form

Patient Name:			Place of Employment:		
Street Address:		City:		State:	Zip Code:
Telephone Home:	Telephone Work:	Telephone Cell:		Email:	
Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Other			
Emergency Contact: Name: _____ Phone Number: _____				How did you hear about us?:	
Auto Related?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Related?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Adjustor / Lawyer / Worker's Comp Name, Claim /Case Number & Telephone:			

### Physician Information

Name of Referring Physician:		Telephone:			
Street Address:		City:		State:	Zip:

### Primary Insurance Information

Insurance Company Name:	Policy #:	Group #:	Policy Holder Name:	Date of Birth:
Policy Holder's Employer:	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other			
Have you received physical therapy/ chiropractic treatments this calendar/policy year?: <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, how many? _____				
Are you currently receiving / or have you had home health care?: <input type="checkbox"/> Yes <input type="checkbox"/> No				

**(Medicare, Medicaid, Self Pay, and Workers Comp patients do not need to fill this section out)**

Please explain your physical therapy coverage through your insurance provider:

Effective date: \_\_\_/\_\_\_/\_\_\_\_\_

Deductible:

Copay:

Coinsurance:

Visits allowed per calendar/policy year:

### Secondary Insurance Information

Insurance Company Name:	Policy #:	Group #:	Policy Holder Name:	Date of Birth:
Policy Holder's Employer:	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other			

Office Use Only

Initial : \_\_\_\_\_ Date: \_\_\_\_\_

Initial : \_\_\_\_\_ Date: \_\_\_\_\_

Initial : \_\_\_\_\_ Date: \_\_\_\_\_

# Hands On Physical Therapy of Mentor, LLC

## Authorization for Treatment Insurance Authorization and Assignment

Can Hands On Physical Therapy leave messages on your answering machine/ voicemail in regards to your physical therapy treatments/appointments?

Yes  No

I request that payment of authorized Medicare/other insurance company benefits be made to Hands On Physical Therapy of Mentor, LLC, for services furnished to me by other party who accepts assignment. Regulation pertaining to Medicare assignment of benefits applies.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or related Medicare/other insurance company claim.

I understand my signature request that payment be made and authorized release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing information to the insurer or agency shown. In Medicare and other contracted insurance company assigned cases, the provider agrees to accept the charge determination of the Medicare/contracted insurance company as the full charge, and I am only responsible for the deductible, coinsurance, and noncovered services/supplies. Coinsurance and the deductible are based upon the charge determination of Medicare/other insurance company.

Your consent authorizes Hands On Physical Therapy of Mentor, LLC for use and/or disclosure of Protected Health Information for purposes of treatment, payment, or healthcare operations.

Yes  No

I hereby give Hands On Physical Therapy of Mentor, LLC the permission to provide physical therapy within the scope and guidelines of the Ohio Physical Therapy Practice Act.

Yes  No

I have been informed of the HIPAA privacy notice and I am aware that a copy of the notice is available upon request.

Yes  No

My signature below acknowledges that I have read and understood the authorizations listed above and hereby give Hands On Physical Therapy of Mentor, LLC permission to act as consented above:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Office Use Only

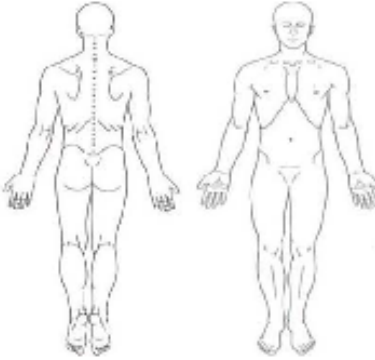
Initial : \_\_\_\_\_ Date: \_\_\_\_\_

Initial : \_\_\_\_\_ Date: \_\_\_\_\_

Initial : \_\_\_\_\_ Date: \_\_\_\_\_

## Pre-Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

<p>1. Please indicate your area of pain or other symptoms with an "x" on the diagram to the right.</p> <p>1 a.) On a scale from 1 to 10, what is the worst your pain has been in the past several days? _____/10</p> <p style="text-align: center;"><i>Mild discomfort</i>                      <i>Moderate</i>                      <i>Unbearable, Severe</i></p> <p style="text-align: center;">1-----5-----10</p>	
<p>2. When did this problem first begin?                  ____ / ____ /20____                  ( approximate date )</p>	<p>3. How did it start?</p>
<p>4. Have you ever had this pain or problem before?  <input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	<p>4a) If yes, did you receive any treatments at that time?  <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>4b) If yes, where?</p>
<p>5. My pain/problem is slowly getting  <input type="checkbox"/> worse      <input type="checkbox"/> better      <input type="checkbox"/> staying the same</p>	<p>6. My pain bothers me  <input type="checkbox"/> constantly      <input type="checkbox"/> most of the time      <input type="checkbox"/> only  <input type="checkbox"/> occasionally      <input type="checkbox"/> once in awhile</p>
<p>7. List the dates and results of any.  <input type="checkbox"/> X-rays:  <input type="checkbox"/> MRI's:</p>	<p>8. Do you have any regular numbness or tingling?  <input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
<p>9. What seems to make your pain worse?                  9a) When it does get worse, how long does it take before calming back down?</p>	
<p>10. What seems to make it feel better?</p>	
<p>I hereby authorize Hands On Physical Therapy of Mentor, LLC and any of its employees to use or disclose my Patient Health Information to my doctor/dentist/lawyer that is listed below:</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>yes</b>, please specify your doctor/dentist/lawyer that can be notified: _____</p>	
<p>Patients that are coming <b>without</b> a doctor's prescription please check one of the following:</p> <p>_____ I would like my physician to be contacted in regards to the results of my physical therapy examination.</p> <p>_____ I would prefer to <b>not</b> have my physician notified of the physical therapy examination at this time.</p>	

Patient Signature: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# Hands On Physical Therapy of Mentor, LLC

11. Have you EVER been diagnosed as having any of the following conditions?

- |                              |   |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Cancer. If yes what kind: _____   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Heart Problems. If yes what kind: _____   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No High blood pressure   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Circulation problems  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Asthma  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Stomach ulcers  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Chemical dependency (i.e., alcoholism)  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Thyroid problems  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Diabetes  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Multiple sclerosis  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Rheumatoid arthritis  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Other arthritic conditions  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Depression  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Hepatitis   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Tuberculosis  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Stroke  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Kidney disease. If yes, what kind: _____  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Blood clots   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Osteoporosis  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Other _____   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No During the past month have you been feeling down, depressed or hopeless?                            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No During the past month have you been bothered by having little interest or pleasure in doing things? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?            |

12. Which of the following medications have you taken in the last week?

	<b>Physician Prescribed</b>		<b>Not Prescribed by Physician</b>	
Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tylenol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anti-inflammatories (Advil/Motrin/Ibuprofen etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach Ulcer Medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vitamins/Mineral Supplements	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Herbals/Remedies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Others NOT mentioned above please list below				

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

13. Please list surgeries / hospitalizations include date and reason

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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Initial : \_\_\_\_\_ Date: \_\_\_\_\_

Initial : \_\_\_\_\_ Date: \_\_\_\_\_