

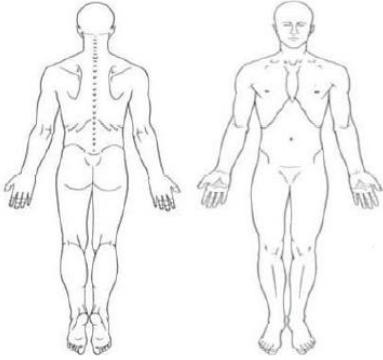
Hands On Physical Therapy of Mentor, LLC

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:			
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					
Can Hands On Physical Therapy leave messages on your answering machine/ voicemail in regards to your physical therapy treatments/appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<p>I hereby authorize any holder of my medical information to release to the agent of Health Care Financing Administration or its intermediaries or carriers, or to any state agency of other primary or secondary insurance carrier, and to a representative of the provider, Hands On Physical Therapy of Mentor, LLC, all such information necessary to determine payment benefits and to file appropriate medical insurance claims made on behalf of Hands On Physical Therapy of Mentor, LLC. Additionally, I hereby request that payment of authorized Medicare benefits or authorized benefits from other primary or secondary insurance carriers be made on my behalf to Hands On Physical Therapy of Mentor, LLC for services performed for me by the provider. I certify that the information given by me in applying for payment under title XVIII of the Social Security Act, Title XIX (Medicaid), and/or any other insurance carrier policy, is correct. I hereby assign by benefits directly to Hands On Physical Therapy of Mentor, LLC as the provider of my services. I understand that if payment is not made directly to the provider by the third party insurance company, I may be responsible for payment to Hands On Physical Therapy of Mentor, LLC for said visit. I understand any balance on my account is expected to be paid in full at all times. (Patient copays will be collected at the start of each treatment).</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p>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.</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p>I have been informed of the HIPAA privacy notice and I am aware that a copy of the notice is available upon request.</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p>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:</p> <p>Signature: _____ Date: _____</p>					
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 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: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Physician Name: _____ Telephone: _____</p> <p>Address: _____ City: _____ State: _____ Zip: _____</p>	
<p>Patients that are coming without 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 not 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?

	Physician Prescribed		Not Prescribed by Physician	
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 ____/____/____

Office Use Only

Initial : _____ Date: _____

Initial : _____ Date: _____

Initial : _____ Date: _____