PATIENT INTAKE FORM

Date:_____

Patient Name:_____
(First) *(Last)* *(Middle)*

Preferred Name or Nickname :_____ **Marital Status :**_____**Gender:**_____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____**Email:**_____

Cellphone_____**Home Phone:**_____

Date of Birth (mm/dd/yyyy):_____/_____/_____ **Age:** _____**Occupation:** _____

Referring Physician: _____ **Primary Care Physician**:_____

Next Doctor's Appointment / Follow-up: _____

How did you hear about Skillz Physical Therapy? _____

EMERGENCY CONTACT
In Case of Emergency, we should contact:

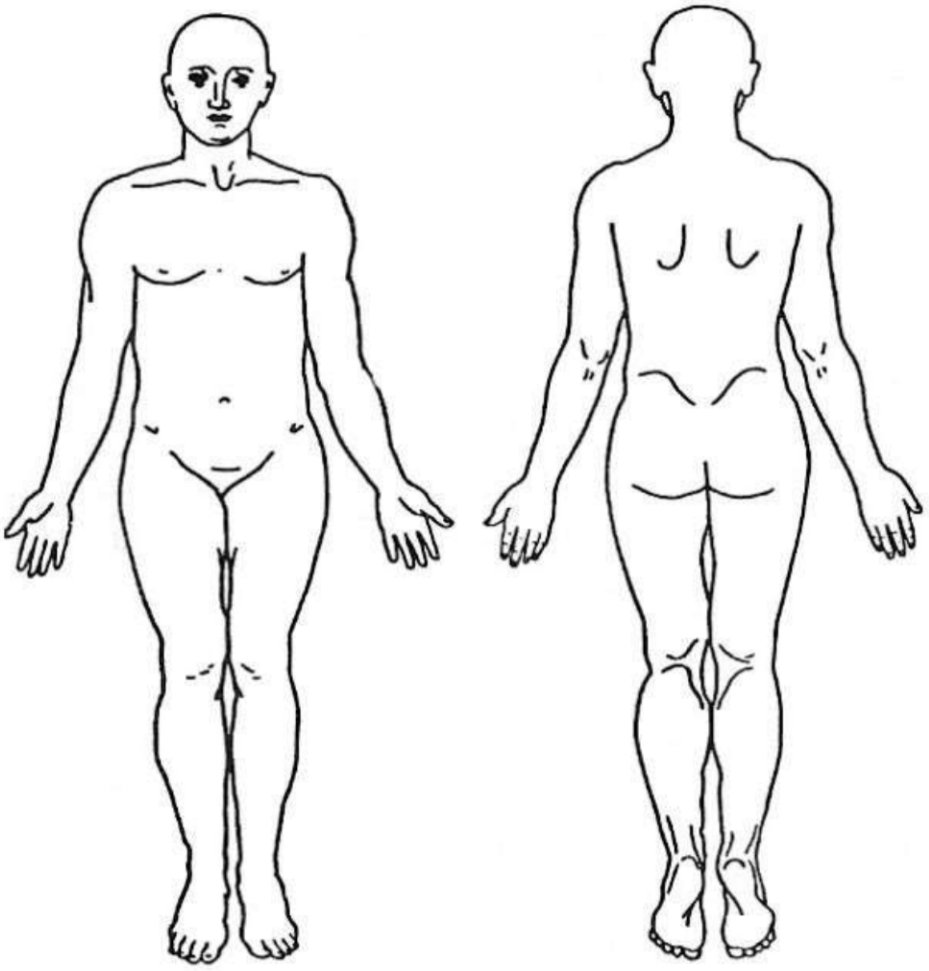
_____	_____	_____
Name	**Relationship**	**Phone Number**

Body Pain Diagram

Please MARK on the diagram where you are experiencing your symptoms and pain.

Indicate which type of symptoms you have:

Deep Ache = ZZZZ **Sharp/Stabbing** = //// **Pins and Needles** = 0000
Burning = XXXX **Throbbing** = WWWW **Dull** = CCCC



My symptoms are getting: ☐ Better ☐ Same ☐ Worse

My symptoms currently: ☐ Come and go ☐ Constant ☐ Constant, but change with activity.

Medical History

Height:_____ Weight: _____

Briefly Describe your symptoms:

How did your symptoms start?

Average pain intensity:
Last 24 hrs (0= no pain, 10=worst that you will go to the ER): _____
Past week: (0= no pain, 10=worst that you will go to the ER): _____

Have you been seen by a medical professional already for your pain/symptoms? ☐ Yes / ☐ No
Please check the box for all that apply:

☐ Primary Doctor	☐ Chiropractor	☐ Ortho Surgeon	☐ ER
☐ Physical Therapist	☐ Acupuncture	☐ Nurse Practitioner	☐Pain Specialist

Other:_____

What activities/movements/positions increase your pain?

What activities/movements/positions decrease your pain?

Are you taking medications for your pain/symptoms? (Please list all medications):

Are you currently experiencing or do you have any history of the following:

Conditions				**Symptoms**		
High Blood Pressure	☐ YES	☐ NO		Dizziness	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO		Recent Fever, Chils, Sweat	☐ YES	☐ NO
Peripheral Vascular Disease	☐ YES	☐ NO		Depression	☐ YES	☐ NO
Pacemaker	☐ YES	☐ NO		Visual Disturbance	☐ YES	☐ NO
Spinal Cord Stimulator	☐ YES	☐ NO		Ringing in Ears	☐ YES	☐ NO
Stroke/ TIA	☐ YES	☐ NO		Hearing Loss	☐ YES	☐ NO
Lung Disease/COPD	☐ YES	☐ NO		Nausea	☐ YES	☐ NO
Blood Clots	☐ YES	☐ NO		Unexplained Weight Changes	☐ YES	☐ NO
Blood Thinners	☐ YES	☐ NO		Headache	☐ YES	☐ NO
Osteoporosis	☐ YES	☐ NO		Difficulty Swallowing	☐ YES	☐ NO
Osteoarthritis	☐ YES	☐ NO		Night Pain	☐ YES	☐ NO
Rheumatoid Arthritis	☐ YES	☐ NO		Chest Pain	☐ YES	☐ NO
Autoimmune Disease	☐ YES	☐ NO		Shortness of Breath	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO		Bowel and Bladder Difficulty	☐ YES	☐ NO
Kidney Disorder	☐ YES	☐ NO		Urinary Tract Infection	☐ YES	☐ NO
Thyroid Disorder	☐ YES	☐ NO		Upper Respiratory Infection	☐ YES	☐ NO
Stomach Ulcers	☐ YES	☐ NO			☐ YES	☐ NO
Hepatitis	☐ YES	☐ NO		Social History		
Cancer	☐ YES	☐ NO		Do you sleep well?	☐ YES	☐ NO
Pregnancy	☐ YES	☐ NO		Do you drink alcohol?	☐ YES	☐ NO
Asthma	☐ YES	☐ NO		Do you use tobacco?	☐ YES	☐ NO
HIV	☐ YES	☐ NO		Do you exercise regularly?	☐ YES	☐ NO

If YES to any condition above, please explain:

List dates and results of any current diagnostics testing (X-ray, MRI, CT scan, EMG, etc):

On a 0-10 scale (0 = no commitment, 10 = fully committed), how committed are you to resolving your pain?

List any known allergies:

List any previous surgeries:

I affirm that the information on this Patient Intake Form is true to my knowledge.

Patient or Parent / Guardian Signature: X_____Date:_____

PATIENT CONSENT TO CARE AND TREATMENT

I understand Skillz Physical Therapy personnel may call my home phone number or other alternative number and leave a voicemail or in-person in reference to appointment reminders, insurance or billing items. I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

CONSENT FOR TREATMENT: I hereby consent to, and authorize my physical therapist, occupational therapist and other health care professionals and assistants who may be involved in my care, to provide care and treatment prescribed by my physician and/or considered necessary or advisable by my physician, physical therapist, occupational therapist or other healthcare professionals. .I understand that a physical therapy diagnosis is not a medical diagnosis by a physician. I understand that my treatment may include techniques that can result in bruising, reddening of the skin, soreness after treatment and hematoma, including, without limitation, myofascial decompression and blood flow restriction, Instrument Assisted Soft Tissue Mobilization, IASTM or Graston Technique®, therapeutic cupping, Kinesiotaping, therapeutic ultrasound and laser therapy. I understand that it is my responsibility to inform my physical therapist, occupational therapist or other health care professional if I experience any discomfort or pain during any treatment or if I have other unresolved concerns around my treatment. I understand that response to physical therapy intervention varies from person to person and it is possible that treatment may result in aggravation of existing symptoms or may cause pain or injury.

APPOINTMENT ATTENDANCE AGREEMENT FOR WORKERS' COMPENSATION PATIENTS: I understand that Skillz Physical Therapy is required to inform my Worker's Compensation Adjustor and/or Rehabilitation Manager of all missed or canceled appointments. I understand that any missed visits must be rescheduled. **INITIALS:_____**

RESPONSIBILITY FOR PAYMENT: All co-payments and self–pay services (i.e IASTM, cupping, dry needling, etc.) are due at the time of service or the day agreed and signed. I acknowledge that in consideration of the services provided to me by Skillz Physical Therapy, I am financially responsible for the payment of my bill. I acknowledge that it is my responsibility to provide Skillz Physical Therapy with my current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that all or a portion of the charges and balance will remain my

personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. I agree to pay any such amounts which are my responsibility. I understand that Skillz Physical Therapy will bill my personal insurance carrier as a courtesy, but that I am ultimately responsible for any amounts owed. If formal collection procedures become necessary, I am responsible for any additional costs incurred as a result of such collection procedures.

If I pay any amount with a check, I hereby authorize Skillz Physical Therapy to use the information from the check to process a one-time Electronic Funds Transfer (EFT/ACH) or a draft drawn from my account. I understand that if my payment is processed as an EFT, funds may be withdrawn from my account as soon as the same day and I will not receive my check back from my financial institution.
INITIALS:_____

ASSIGNMENT OF BENEFITS: I hereby assign to Skillz Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to cooperate with Skillz Physical Therapy and to provide such information as is needed to establish my eligibility for such benefits.

CANCELLATION AND LATE POLICY: CANCELLATIONS: There is a **$10 CANCELLATION FEE** if you do not call at least 24 hrs in advance to cancel or reschedule and a **$25 NO SHOW FEE** to an appointment or evaluation. **INITIALS:**_____

Please note that refusal to sign this form does not change responsibility for payment in any way.

LATE EVALUATIONS: If you are late to an evaluation, you can contact Skillz Physical Therapy directly at off-hours phone number (847) 877-0804 or office number (847) 859-0804 and decide whether you would like to continue with the evaluation or reschedule. If you are less than 15 min late, the duration of the evaluation will still end at the scheduled time and the cost will still be the same to complete the evaluation. If you are more than 15 min late it is left up to the discretion of the therapist regarding rescheduling vs completing a shorter evaluation with less or no treatment. The eval will still end at the scheduled time and the cost is the same.

LATE TREATMENT APPOINTMENTS: If you are going to be late to a treatment appointment, you can contact Skillz Physical Therapy directly at off-hours phone number (847) 877-0804 or at the Evanston or Northbrook location office number, and decide whether you wish to continue with your appointment or reschedule. If greater than 15 minutes: you can reschedule or choose to pursue a shorter treatment but the session will still end at the same scheduled time.

ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that Skillz Physical Therapy may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Skillz Physical Therapy's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Skillz Physical Therapy's Notice of Privacy Practices and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information.

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By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____

Printed Name of Patient

_____ _____

Signature of Patient or Legally Responsible Person **Date**

_____ _____

Printed Name (if not the Patient) **Date**

Skillz Physical Therapy complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

2020.23.02