PERFORMANCE+PLUS PHYSICAL THERAPY

INTAKE FORM

Personal Information

DOB (MM/DD/YYYY): _____

Last Name: _____ First Name: _____

Phone Number: _____ Email Address: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Status: ☐ Single ☐ Married ☐ Other

Hobbies: _____ How did you hear about us? _____

Injury

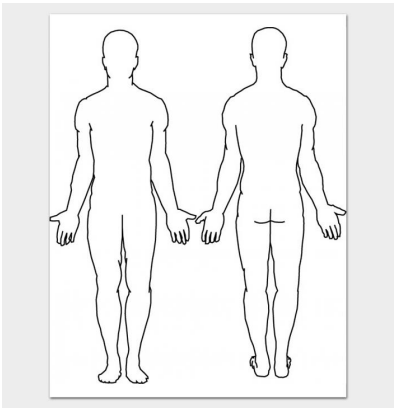
Body Part: _____ Injury Date: _____ Surgery Date: _____

Please describe what brings you in today: _____

_____

_____

Please use the diagram below to mark the location of your current symptoms .



My symptoms are: ___Constant ___Intermittent ___Chronic _New

My symptoms are made better by: _____

_____

My symptoms are made worse by: _____

_____

What is your pain rating in the last 24 hours?

1 2 3 4 5 6 7 8 9 10

What is your goal for physical therapy? _____

How often do you exercise more than 20 min. per day? __1x a week __2x a week __3x a week __4x a week __5x List any

recent diagnostics (Xray, MRI, CT Scan, Injections, etc): _____

Are you on any medications? _____

_____

Allergies: _____

Medical History

__Fatigue
__Constipation
__Visual Changes
__Incontinence
__Fainting
__Nausea/ Vomiting
__Fever/ Sweats/ Chills
__Difficulty Swallowing
__Dizziness/ Lightheaded
__Muscle Weakness
__Bowel/ Bladder Changes
__Unexplained Weight Gain/ Loss
__Pain that Keeps you Awake
__Rapid Heart Rate/ Palpitations
__Recent Onset of Headaches
__Shortness of Breath
__Numbness/ Tingling
__Heartburn/ Indigestion
__Unexplained Cough
__Falls

__Prior Surgeries. Please Describe: _____

Have you been diagnosed with any of the following

__Anemia
__Asthma
__Pneumonia
__Cancer(Any)
__Stroke/CVA/TIA
__Thyroid Condition
__Bone/ Joint
__Infections Seizures or
__Epilepsy
__Diabetes Type 1/2
__Chronic Headaches
__TB/ HIV/ Hepatitis A B C
__ Chest Pain
__High/ Low Blood Pressure
__Lung Disease/COPD/ARDS
__Bladder/ Urinary/ Kidney Disease
__Osteoarthritis/ Rheumatoid Arthritis
__Congestive Heart Failure
__Visual or Hearing Impairments
__Back Pain
__GI Disease (Liver, Ulcer, Hernia, Reflex, Gall Bladder)
__Vascular/ Circulation Problems/ Blood Clots
__Depression/Anxiety/Panic Disorders
__Neurological Disease
__Osteoporosis

The above information is complete, true and correct to the best of my knowledge.

Patient Name: _____ Signature: _____ Date: _____

Registration Form

INSURANCE INFORMATION

Primary Insurance

Name: _____
Phone Number: _____
Policy ID Number: _____
SSN/ Benefits Number: _____

Secondary Insurance

Name: _____
Phone Number: _____
Policy ID Number: _____
SSN/ Benefits Number: _____

Medicare? Y / N Have you had Physical Therapy this calendar year? _____ Visits
Are you currently in Home Health? Y / N

Would you like to receive appointment reminders via: ___ Email ___ Text

Emergency Contact/Relationship: _____ Phone : _____

Do you have a prescription from a physician or provider for physical therapy? ___Yes ___ No
If yes, who is your referring physician? _____ Phone: _____
Return to Doctor Date: _____

>Are you seeking Physical Therapy because of a work related accident? ___ Yes ___ No
>Employer Name: _____ Phone: _____
>Employer Address: _____
ADJUSTER: _____ Phone: _____ Fax: _____

>Are you seeking Physical Therapy because of a car accident? ___Yes ___No

Car Insurance: _____ Phone: _____

Are you seeking Physical Therapy through a Personal Injury Case ___ Yes ___No
Case Number: _____ Attorney: _____
Address: _____
Phone: _____ Fax: _____

Patient Consent

Consent for Care and Treatment: I hereby agree and give my consent to Performance Plus Physical Therapy to furnish appropriate rehabilitative care and treatment, as considered necessary and in the best interest in order to attend to the physical condition. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters.

Notice of Patient Information Practices: I have read and fully understand Performance Plus Physical Therapy's notice of Information Practices.

Authorization to Release Patient Information: I hereby authorize Performance Plus Physical Therapy to release any protected health information (PHI) required in the course of my examination or treatment to the insurance company, or their affiliates, of which i provided the information.
I also authorize the release of appointment information left in a voice-mail, answering machine, or text message and understand the level of privacy risk associated with these forms of communication.

HIPAA Consents: In compliance with the HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account.

Name/ Relation/ DOB: _____ **Name/ Relation/ DOB:** _____

Authorization to Pay: I hereby authorize payment directly to Performance Plus Physical Therapy, billing department, for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

Attendance Agreement: At Performance Plus Physical Therapy, we understand that scheduling conflicts occur and we will make every effort to accommodate you. As such, we will apply a fee to your account for same day cancellation ($25) or no show without notice ($50). If you should miss more than three appointments in a row you will be discharged as a patient, and your care will be turned back over to you referring physician.

*Workers Compensation:*We are required to inform the carrier of all missed or canceled appointment. It is also required to rescheduled all missed appointments.

Authorization to Communicate Electronically: I understand authorized personnel from Performance Plus Physical Therapy may communicate with me regarding scheduling/ appointments, the treatment provided, home exercise programs, and educational content as it relates to my condition. I understand that my protected information will not be communicated electronically. I understand that I have the right to opt out of all future communications at anytime using the "unsubscribe" option on any forms/ text/email.

My signature below certifies that I've read , understand and fully agree to each statement in the document.

Patient Name: _____ Signature: _____ Date: _____

List of Treatments

Soft Tissue Mobilization

Soft tissue mobilization will help decrease tightness. tone, stress and pressure to surrounding areas. It will Increase blood flow, mobility, flexibility and range of motion. Soft tissue mobilization promotes fiber realignment and collagen lengthening.
Risk factors: Soreness, bruising. petechiae, contusions, Increase heart rate, Increase respiratory rate.

Joint Mobilization/ High Velocity, Low Amplitude Thrust Techniques

Joint mobilization will help Increase Joint flexibility, blood flow and nutrition, range of motion and Joint lubrication. It will also help decrease scar tissue, adhesions and risk of frozen joints capsulitis),
Risk factors: Soreness, sprains, strains, joint fractures, bruising.

Stretching

Stretching will help increase blood flow, collagen pliability, lengthening, mobility, flexibility and range of motion. It will also help decrease stress to surrounding areas.
Risk factors: Soreness, strains, tears, decreased muscle performance.

Exercises

Exercising will help increase strength, motor control, neuromuscular control, stability, balance, blood flow and Joint lubrication. It will help Improve cardiovascular endurance, aerobic endurance, anaerobic strength, function with ADL's, posture, gait and neurological function. Exercising will help decrease the risk of cancer, obesity, risk of heart disease, adhesions and tightness. It promotes healing and helps with circulation.
Risk factors: Soreness, sprains. strains, Joint fractures, Increase heart rate, Increase respiratory rate, Increase fatigue, muscular pain, Joint pain, dizziness.

Myofascial Decompression

Myofascial decompression Is soft tissue stretching that helps Increase blood flow. mobility, flexibility and facilitate healing. It will help with neuromuscular reeducation, Improve motor control and eliminate toxins.
Risk factors: Soreness, petechiae, bruising and discoloration, Increase body temperature, vasovagal response, Increase heart rate, Increase respiratory rate. Irritation to stein, over stretching of skin. sort tissue strain.

Electrical Stimulation

Electrical stimulation E-stim) helps decrease pain, tightness, tone and scar tissue. It helps Increase blood flow and nutrition as well as circulation. E-stim helps with neuromuscular control (NMES), muscle strengthening and muscle reeducation.
Risk factors: Pain, burns, shock, heart palpitation, nerve pain, muscular pain.

Taping

Taping helps with neuromuscular reeducation, postural control, strengthening and stability. it also helps increase flexibility.
*Risk factor*s: Skin irritation, soreness.

Ice

Ice will help decrease inflammation, blood flow, vasoconstriction and pain. It will also help promote healing.
Risk factors: Skin irritation, stiffness, soreness, burn

Heat

Heat will help increase blood flow and decrease tightness and pain. It will also help promote healing relaxation.
Risk factors: Burns, increase inflammation, increase heart rate, increase respiratory rate, increase blood pressure.

Mechanical Traction/ Manual Traction

Mechanical traction Is a device used to provide a longitudinal force to the cervical or lumbar spine. Traction Increases the space between your vertebrae and stretches surrounding muscles to relieve pain due to nerve impingement.
Risk factors: Sprains. strains, bruising, Joint fractures. and decreased muscle performance.

Aquatic Therapy

Aquatic therapy will help decrease compression and Impact on Joints and muscles. It will help with strengthening, flexibility, blood now, circulation. and blood return. It will also help with hydration of the Joints and discs. Aquatic therapy
will help with balance, assistance of range of motion, cardiovascular endurance, respiratory function. neuromuscular education. gait training, core strengthening and lymphatic drainage. It will also promote hydrostatic pressure for blood return and edema reduction.
Risk factors: Drowning, skin Irritation, soreness. sensitivity to the cold, sensitivity to the sun, muscular strain, joint strain.

1. I understand and acknowledge the risks as described above.
2. I authorize PPPT to evaluate my condition and Implement a treatment program for me to carry out.
3. I agree to Immediately report any Increase h pain or discomfort or any change in my physical condition to my therapist so that my treatment program can be adjusted appropriately.
4. I authorize PPPT to communicate with my doctor concerning my physical condition and treatment program.

Patient Name:_____ Signature:_____ Date: _____