PATIENT INTAKE FORM - PATIENT INFORMATION

First Name________________ M.I.________ Last Name ______________________________

Cell Phone ______________________ Email ________________________________

DOB______________ Age ________ Sex ______________ Height ____________ Weight ____________

Address ________________________ City ____________________ State _______ Zip _________

Responsible Party Name (For Minors)____________________ Relationship to Minor____________________

Address (if different from above)________________________ Occupation ___________________________

Primary Care Physician_________________________ Physician Number ____________________________

Reason For Visit ____ Date of Injury / Onset______________

Is your overall condition improving? ☐ Yes ☐No

Have you experienced these symptoms before? ☐ Yes ☐No

How did you hear about Missing Link Physical Therapy?

☐Referral/Friend ☐Google ☐Facebook/IG ☐Yelp ☐Other: ____________________________

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PHYSICAL THERAPY
Where Mind, Body & Soul Connect

PATIENT INTAKE FORM - CURRENT HISTORY

What date (approx.) did you present symptoms start? ______________________________

How did this first happen? ______________________________

How have your symptoms changed? ☐ Getting better ☐ About the same ☐ Getting worse

What makes your symptoms better? ______________________________

What makes your symptoms worse? ______________________________

Have you had an X-Ray, MRI, or other testing for this problem? ☐ No ☐ Yes *If yes, specify* ______________

What treatments have you received for this problem so far? ______________________________

Aggravating Factors: Identify 3 important activites you are unable to do or have difficulty with because of your problem

1. ______________________________
2. ______________________________
3. ______________________________

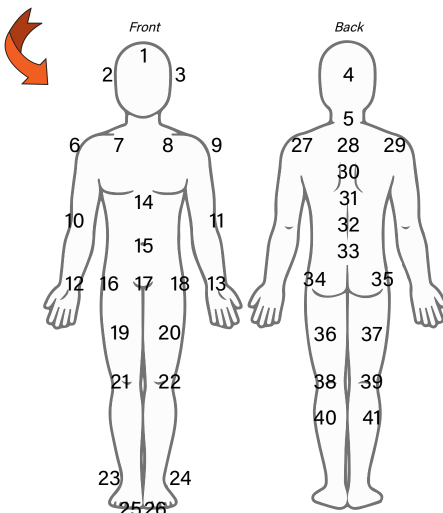
During the past 3 months, have you seen any medical professional (medical doctor, chiropractor, physical therapist, osteopath, etc.)?

☐ Yes ☐ No *If yes, describe the reason* ______________________________

What are your personal goals for therapy at this time? ______________________________

List any physical activities you participate in (running, swimming, tennis, etc.): ______________

Using the numbered chart below, please list the areas where you feel your symptoms: ______________



On the scale below, select the number which best represents the average level of pain you are **currently experiencing**:

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

No Pain — *Worst pain imaginable*

Level of pain at the worst:

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

No Pain — *Worst pain imaginable*

Level of pain at the best:

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

No Pain — *Worst pain imaginable*

What best represents your overall average level of function:

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

Cannot do anything — *Able to do*

PATIENT INTAKE FORM - MEDICAL HISTORY

PLEASE CHECK IF YOU HAVE, OR HAD ANY OF THE FOLLOWING BELOW:

☐Diabetes
☐Chest Pain / Angina
☐Heart Disease
☐High Blood Pressure
☐Heart Attack
☐Pacemaker
☐Vascular Disease
☐CVA/Stroke/TIA
☐Seizures
☐Skin Abnormalities
☐Sexual Dysfunction
☐Nausea / Vomiting

☐COPD
☐Thyroid Disease
☐Osteoporosis / Osteopenia
☐Arthritis
☐Hernia
☐Recent Fractures
☐Headaches / Migraines
☐Dizziness / Fainting
☐Kidney Disease
☐Bowel / Bladder Disease
☐Liver / Gallbladder Disease
☐Metal Implants

☐Ringing / Fullness in the Ear
☐HIV
☐Hepatitis
☐Asthma
☐Depression
☐Anxiety
☐Allergies
☐Cancer: ______________________________

Are you pregnant? ☐Yes ☐No
Do you smoke? ☐Yes ☐No

Have you had surgery related to this condition? ☐Yes ☐No

If yes, what type of surgery? ______________________________ Date of surgery: ______________________________

Please list all surgeries you have had and dates: ______________________________

Please list all medications: ______________________________

PATIENT INTAKE FORM - ACKNOWLEDGEMENTS & CONSENT

RELEASE OF HEALTH INFORMATION

I give permission to Missing Link Physical Therapy to release information, verbal and written, from my medical records to my physician, insurance company, case manager, attorney, school, related healthcare provider, or other agencies as it relates to my treatment. I further authorize Missing Link Physical Therapy to obtain medical records from my physician or other medical professionals as related to my treatment.

Initial Here ___________

DISCLOSURE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I have read and fully understand Missing Link Physical Therapy's Privacy Practices. A copy of Privacy Practices is available in the front waiting area or a hard copy may be obtained upon request. I understand that Missing Link Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Missing Link Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Missing Link Physical Therapy Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initial Here ___________

COMMUNICATION OF HEALTH INFORMATION

I give permission to Missing Link Physical Therapy to disclose and discuss any information related to my medical condition(s) with the following individuals:

Name:______________________ Relationship:________________ Contact Info:________________________
Name:______________________ Relationship:________________ Contact Info:________________________
Name:______________________ Relationship:________________ Contact Info:________________________

☐I **do not** wish to disclose any information related to my medical condition(s)

Initial Here ___________

MEDICARE

Please note if Physical Therapy services are no longer reimbursed by Medicare you will be responsible for payment of services provided.

I request all authorized Medicare payments to be made on my behalf to Missing link Physical Therapy for services rendered to me. I also authorize release of any information to my Medicare insurer and their agents needed to determine payable benefits for services rendered.

Initial Here ___________

FINANCIAL / SCHEDULING POLICY

We are committed to providing you with the best possible care. This information is designed to guide you through the rapidly changing world of physical therapy and insurance plans. **Please read carefully and sign at the bottom of the page indicating your understanding and acceptance of our policies and procedures.**

Here at Missing Link Physical Therapy, we feel that we can best care for our patients if we are able to spend up to a full hour with our new patients on their first appointment. Because of the high demand for these appointments it is critical that you arrive in the office 10 minutes prior to your appointment with your completed forms. We understand that delays can happen, however, we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.**

We understand situations arise in which you must cancel your appointment. It is therefore requested if you must cancel or reschedule your appointment, you provide more than 24 hours notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations / reschedules made less than 24 hours notice, we are unable to offer that appointment to other patients.

There will be a $150.00 fee charged to all patients / clients who miss scheduled appointments and fail to cancel their scheduled appointment without 24 hours notice. We understand that illness and emergencies happen and we will take that into full consideration if the situation arises and will waive the fee as necessary. Patients who No Show two (2) or more times in a twelve (12) month period, may be dismissed from the practice thus being denied any future appointments.

Missing Link Physical Therapy is an out of network Physical Therapy practice. Payment is to be provided on the date of services unless payment arrangements have been made and approved in advance. We will provide the appropriate invoice so that you may submit the service provided to your insurance company for possible reimbursement. For your convenience, we accept all major credit cards and payments can be made over the phone. **PLEASE NOTE THAT YOU WILL BE CHARGED $35.00 FOR ANY CHECKS WITH NONSUFFICIENT FUNDS.**

Initial Here ___________

CONSENT AND RELEASE FOR TRIGGER POINT DRY NEEDLING PROCEDURE (TDN)

This form is a consent form and general release of medical liability for the TDN procedure. By signing this form, you are agreeing not to hold Missing Link Physical Therapy or its staff liable for any complications that may arise from the usual application of this procedure. Prior to receiving TDN you will be "verbally consented." This means you will be asked if you want to proceed. If you state "yes," you will not be asked to sign this form again. This form will be kept on file. You may request a copy of this consent form for your records.

DESCRIPTION OF PROCEDURE:
During treatment for many of our patients, we commonly use a technique referred to as Trigger Point Dry Needling (TDN). In many cases, TDN can be helpful in resolving sub-acute and chronic pain. TDN may be very effective for your medical condition. TDN involves placing an acupuncture needle into the muscle in order to release muscle and decrease trigger point activity. This can help resolve pain, release muscle tension, and promote healing. This is NOT traditional Chinese Acupuncture, but instead a medical treatment that relied on a medical dagnosis to be effective. All Physical Therapists at Missing Link Physical Therapy have met the requirements for Level I and Level II TDN training and have years of experience in performing the procedure.

RISKS OF PROCEDURE:
While complications from receiving TDN are rate in occurrence, they are real and must be considered prior to giving consent for treatment. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest X-Ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and reinflation of the lung. This is a rare compli1cation, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection and or nerve injury. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. Additional possible complications include possible increased pain or other symptoms. As the needles are very small and do not have a cutting edge, the likelihood of any significant trauma from TDN is minimal.

Initial here ____________

CONSENT TO PHYSICAL THERAPY

1. CONSENT TO TREATMENT: I consent to rehabilitation and related services at Missing Link Physical Therapy. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and / or direct contact of a sensitive nature.
2. TREATMENT OF MINORS: I, as parent / guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.
3. LIABILITY: I know and agree that Missing Link Physical Therapy is not responsible for loss or damage to personal valuables.
4. WAIVER AND RELEASE: I hereby release, discharge and acquit Missing Link Physical Therapy, its agents, representatives, affiliates, employees, or assigns, of any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service Emergency Medical Technician, physician or urgent care services.
5. AUTHORIZATION OF PAYMENT: I consent that I will provide full payment to Missing Link Physical Therapy on services provided on that day of service.

I certify that all information provided herein is true and correct.

Patient Signature ____ Date________________