Patient Information

Last Name	First Name	Middle Initial

Address	City	State	Zip Code

Home Phone	Cell Phone	E-mail

Date of Birth	SSN	Sex	Status
		☐ Male ☐ Female	☐ Single ☐ Married ☐ Other

Employer Information

Employer Name	Employment Status ☐ None ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Self-Employed

Work Phone	Work Address	Occupation

Primary Insurance Carrier / Policy Holder Information

Primary Insurance	Insurance Identification Number

Policy Holder Name	Date of Birth	Relationship to Patient

Policy Holder Home Phone	Policy Holder SSN	Policy Holder Address

Secondary Insurance Carrier / Policy Holder Information

Primary Insurance	Insurance Identification Number

Policy Holder Name	Date of Birth	Relationship to Patient

Policy Holder Home Phone	Policy Holder SSN	Policy Holder Address

Physician Information

Name of Referring Physician	Name of Primary Care Physician

Emergency Contact Information

Contact Name	Phone Number	Relationship to Patient

Additional Information

Date of Injury / Onset Date	Accident Related?	Work Related?	Diagnosis / Area of Injury

Post-Surgical?	Type of Surgery	Date of Surgery	Have you had prior therapy this year? (PT/OT/SP Chiropractic)

Intake Completed By: [office use]	***I acknowledge that the above information is correct***
Name: Date:	Patient/Guardian: Date:

Medication List

Please list all medications you are currently taking. Include all prescription and over-the-counter medications as well as supplements.

Name: ____ Date of Birth: ____________________

Medication	Dose	Frequency	Date Started	Date Stopped

Signature: ____ Date: __________________________

MEDICAL HISTORY SCREENING FORM

To best serve your needs and understand your medical condition – please complete the following.

Condition	Patient		Family	
Cancer: ______________________________	Yes	No	Yes	No
Diabetes: Type I Type II	Yes	No	Yes	No
High blood pressure	Yes	No	Yes	No
Heart Disease / Heart Attack	Yes	No	Yes	No
Angina / Chest Pain	Yes	No	Yes	No
Stroke	Yes	No	Yes	No
Osteoporosis / Osteopenia	Yes	No	Yes	No
Osteoarthritis	Yes	No	Yes	No
Rheumatoid Arthritis	Yes	No	Yes	No
Other: ______________________________	Yes	No	Yes	No

Do you have a history of?

Allergies / Asthma	Yes	No	Dizziness / Balance Problems	Yes	No
Headaches	Yes	No	Are you pregnant?	Yes	No
Bronchitis	Yes	No	Sensitive to Heat / Ice?	Yes	No
Kidney Disease / Problems	Yes	No	Anxiety / Depression	Yes	No
Rheumatic Fever	Yes	No	Fibromyalgia	Yes	No
Ulcers	Yes	No	Fracture / Suspected Fracture	Yes	No
Seizures	Yes	No	Traumatic Brain Injury (TBI)	Yes	No
Parkinson's Disease	Yes	No	Bowel / Bladder Changes	Yes	No
Hernia	Yes	No	Unexplained weight gain or loss	Yes	No
Metal Implants	Yes	No	Nausea / Vomiting	Yes	No
Pacemaker	Yes	No	Health change within the past 3 months?	Yes	No

Height: _______________ Weight: _______________

Patient Signature: _______________________________________ Date: ____________________

CURRENT INJURY / DISORDER INFORMATION

Patient Name: _________________________________ **Referring Doctor**: ______________________________

Type of Injury/Disorder/Concern: ____

Is this injury related to: (Please circle.)

Work Auto School Sports Recreational Sports Other: ________________________

Please describe how and when the injury/disorder occurred: ____

____

Please answer the following regarding your pain/symptoms. (*Please circle one*)

My pain is worse in the:

Morning Evening Same Fluctuates Constant

What is your level of pain right now?

No Pain/0 1 2 3 4 5 6 7 8 9 10/Worst Pain Ever

Please list any activities that INCREASE your pain/symptoms: ____

____

Please list any activities that DECREASE your pain/symptoms: ____

____

***ARE YOU CURRENTLY RECEIVING OR HAVE YOU RECEIVED HOME HEALTH CARE WITHIN PAST 60 DAYS?** YES NO

If yes, what dates did you receive services? ___________________________________

Company Name? ____

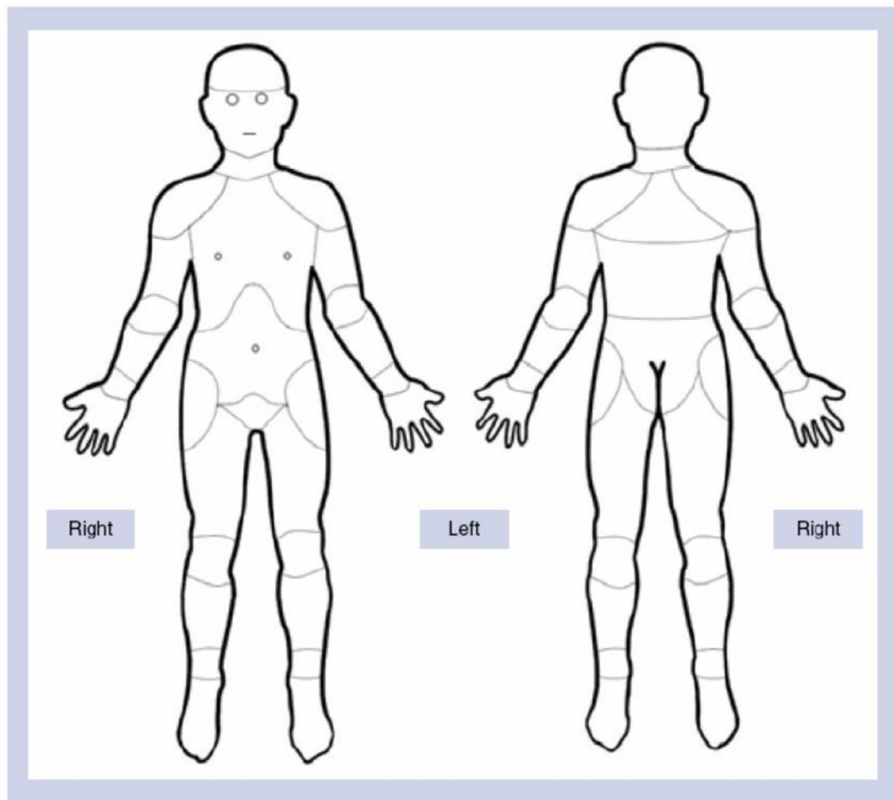
***HAVE YOU RECEIVED PHYSICAL THERAPY WITHIN THE CALENDAR YEAR?** YES NO

If yes, where was the treatment? ____Inpatient ____Outpatient

Please describe your pain. (Check all that apply):

- ☐ Sharp
- ☐ Pulling
- ☐ Stabbing
- ☐ Shooting
- ☐ Burning
- ☐ Tight
- ☐ Dull
- ☐ Throbbing
- ☐ Ache

- ☐ Tingling / Numbness
- ☐ Constant (Never goes away)
- ☐ Intermittent (relieved with some positions or rest)
- ☐ Occasionally (Daily or less frequent)
- ☐ Infrequently (once a week or month)
- ☐ Previously (No longer present)
- ☐ Variable (Sometimes worse than other times)



SHADE AREA OF PAIN ON THE DIAGRAM

Patient Signature: ____ Date: ______________

How did you hear about Mountain Valley Physical Therapy? (Please circle)

Physician Website/Advertisement Friend/Family/Co-worker Insurance Company

Coach/Athletic Trainer Other: ___________________________________

Health Information Disclosure

By signing this form, I consent to Mountain Valley Physical Therapy use and disclosure of my health information for treatment, payment, or health care operations.

I hereby give my permission to the person(s) listed below to authorize treatment and to receive information about the care of the patient named below.

Name	Relationship

In order for the person(s) listed above to obtain information by telephone, the party calling the practice must provide the following patient identifier. ____

Responsible Party

Print Patient Name: ____ Date of Birth: _______________

Signature of Patient or Responsible Party: ____ Date: ___________

Missed Appointment and Cancellation Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to a seemingly full appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty dollar ($20) fee. This will not be covered by your insurance.

I agree to the above policy regarding missed appointments and cancellations.

Patient Name: ____

Patient Signature: _____________________________________

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient

"I have received a copy of Mountain Valley Physical Therapy's Notice of Privacy Practices effective 9/12/2019."

Name (please print): ___________________________________
Signature: ____
Date: _______________________

Guardian

"I am a parent or legal guardian of _____________________________ (patient name). I have received a copy of Mountain Valley Physical Therapy's Notice of Privacy Practices effective 9/12/2019."

Name (please print): ____________________________________
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: ____
Date: ______________________________

Staff Only

If the individual or parent/legal guardian did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective 9/12/2019 given to individual on _______________ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other ______________________

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _______________________________________

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation ____
☐ Telephone contact ____
☐ Mailing ____
☐ Email ____
☐ Other _______________________________________

Staff Name (please print): ________________________________ Title: ______________

Signature: ___________________________________ Date: ______________________