ANDERS AND ASSOCIATES
PHYSICAL THERAPY

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Patient Intake Form

Patient Information

Name: _____ Date: _____

Address: _____

Date of Birth: _____-_____-_____ Social Security Number: _____-_____-_____

Age: _____ Weight: _____ Height_____ Sex: M F

Marital Status: _____ Number of children: _____

Occupation: _____ Currently Working? Yes No

Employer: _____ Work Phone: _____

Employer Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

If under 18 years of age:

Name of Parent or Guardian: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relation to Patient: _____

Primary Care Physician (PCP): _____ Phone: _____

PCP Address: _____

Were you referred to us by your PCP? Yes No Date of next apt with referring PCP: _____

Do you have a prescription for Physical Therapy from your PCP? Yes No

How did you hear about Anders and Associates Physical Therapy? _____

Insurance Information:

Primary Insurance: _____ Coverage effective from _____ to _____

Patient Name: _____ **D.O.B:** _____-_____-_____ **SS#** _____-_____-_____

Policy Holder: _____ Relationship _____ Call Ref # _____

Social Security Number of Policy Holder: _____-_____-_____ D.O.B. of policy holder _____-_____-_____

Health Plan: _____ **Medicare Number (if applicable):** _____

Member ID: _____ **Group Number:** _____

HMO _____ PPO _____ In Network: Yes No Copay: $_____ Coinsurance _____

Prescription needed Yes No Exclusions: _____ Provisions: _____

Secondary Insurance: _____ Coverage effective from _____ to _____

Policy Holder: _____ Relationship _____ Call Ref # _____

Social Security Number of Policy Holder: _____-_____-_____ D.O.B. of policy holder _____-_____-_____

Health Plan: _____ **Medicaid Number (if applicable):** _____

Member ID: _____ **Group Number:** _____

HMO _____ PPO _____ Deductible:_____ Amount left:_____ Copay:$ _____ Coinsurance:_____

Prescription needed Yes No Exclusions: _____ Provisions: _____

Insurance Name #3 _____ Cov. Eff. _____ Call Ref # _____

Basic Benefits			Primary
Annual Deductible	Yes	No	$ _____
Deductible Applied to Date			$ _____
Calendar Year Maximum (Out of Pocket)			_____
Will Two Body Parts be Paid for on the Same Day?			Yes No
Pre-Certification/Authorization Required?	Yes	No	Authorization #: _____
Visits Authorized/End Date (If applicable)			_____
PT/OT/Chiropractic Visits Allowed	Yes	No	#/$ _____
If so, how many/much used?			_____

Verified by: _____

I have reviewed the above information and understand it is only an estimation of the benefits covered by my insurance carrier. It is not a guarantee of payment. I understand that I am responsible for the payment of services estimated to be covered, and any non-covered service as determined by my insurance carrier. I understand my insurance determines the number of therapy visits allowed, and/or the maximum amount they will reimburse. I understand that my insurance has set these limits and that I will be responsible if any benefit limits are exceeded. I understand that I should contact my insurance to confirm my individual benefits for physical therapy.

Patient or Guardian Signature: _____ **Date:** _____

Health History

Presenting Complaints:

What are you coming into Physical Therapy for? _____

_____

Were you involved in an accident? Yes No

How did this injury or problem occur? _____

_____

When did you start experiencing symptoms, OR Date of Injury? _____

Did you have surgery for this condition? If yes, what surgery and when? _____

_____

Have you had this problem before? Yes No

If yes, please describe when and what treatment you received: _____

_____

Please list how this problem affects your daily activities: _____

_____

Are you seeing, or have you been seen by, any other specialists for your current condition? (i.e. doctor, psychologist, chiropractor, etc.) Please list: _____

_____

Have you been treated by another physical therapist in the past? If so, by whom and when? _____

_____

What tests have you had for this condition? Circle all that apply: X-ray MRI CT scan

Please list any other tests that you've had for this condition: _____

_____

Current and Past Medical History

Have you experienced recent weight loss? Yes No

Do you have low blood sugar? Yes No

Have you had any falls in the past 12 months? Yes No If so, how many times? _____

Did these falls result in injury? If so, please describe: _____

Do you have a history of fractures? If so, please list them and when they happened: _____

_____

Have you ever had major surgery? If so, please list what kind and when it was performed: _____

_____

Have you ever had any major accidents or falls? Yes No If so, please list them: _____

_____

Have you ever been diagnosed and/or treated for any of the following conditions?

Please circle yes or no for each condition as they might apply to you:

Cancer	**Yes**	**No**	Osteoarthritis	**Yes**	**No**
High Blood Pressure	**Yes**	**No**	Rheumatoid Arthritis	**Yes**	**No**
Heart Attack	**Yes**	**No**	Kidney problems	**Yes**	**No**
Heart problems	**Yes**	**No**	Epilepsy	**Yes**	**No**
Headaches	**Yes**	**No**	Seizure	**Yes**	**No**
Migraines	**Yes**	**No**	Hepatitis	**Yes**	**No**
Stroke	**Yes**	**No**	Thyroid problems	**Yes**	**No**
Depression	**Yes**	**No**	Tuberculosis	**Yes**	**No**
Emphysema	**Yes**	**No**	Drug Dependency	**Yes**	**No**
Multiple Sclerosis	**Yes**	**No**	Alcoholism	**Yes**	**No**
Anemia	**Yes**	**No**	Breathing Difficulties	**Yes**	**No**
Osteoporosis	**Yes**	**No**	Shortness of breath	**Yes**	**No**
Angina (chest pain)	**Yes**	**No**	Lung disease	**Yes**	**No**
Impaired vision	**Yes**	**No**	Asthma	**Yes**	**No**
Impaired hearing	**Yes**	**No**	Dizziness	**Yes**	**No**
Bowel Problems	**Yes**	**No**	Bladder Problems	**Yes**	**No**
HIV/AIDS	**Yes**	**No**	Blood Disorders	**Yes**	**No**
Diabetes	**Yes**	**No**	Clotting Disorders	**Yes**	**No**
Pacemaker	**Yes**	**No**	Defibrillator	**Yes**	**No**

Are you currently pregnant? Yes No

Please describe any other relevant problems: _____

_____

Please list any allergies that you have: (ex. medications, food, environmental, etc.) _____

_____

If you have ever been hospitalized for any condition other than the one mentioned, please list what for and when? _____

_____

Please list all medications that you are taking, dosages, and reasons for taking them: (you may attach a separate list) _____

_____

_____

_____

The purpose of this questionnaire is to assist us in providing you with quality care by obtaining a better understanding of your total health status. We appreciate your completion of this questionnaire. Should you have any questions or need to share additional information, please discuss them with your therapist. This questionnaire along with all health discussions are considered part of your confidential medical record.

The above information is true to the best of my knowledge:

Patient or Guardian Signature_____ Date_____