Professional Physical Therapy and Associates Ltd. Co.

1316 S Ridgewood Ave (U.S. 1), Suite 1• Edgewater, FL 32132 • Tel: (386) 423-0100 • Fax: (386) 428-8631 • www.Proptfl.com

PATIENT INTAKE FORM

NAME:_________________________________ DATE OF BIRTH:____/____/______

Nickname:____________________________ Social Security #:______________________

Local Address:____

City:________________________________ State:_________________ Zip Code:___________

*(Please check preferred method of contact)

- Home Phone:________-_______-________
- Cell Phone:________-_______-________

*(Does cell phone have Text Ability: Yes / No)

*Email Address:____

*(Used for mailing purposes and Home Exercise Programs)

Occupation:____

Place of Employment:____

Ins. Company: Name:_____________________________ Policy #:________________________

Is This Work Related or Due to Auto Accident? Yes / No If Yes, Claim#:___________________

Adjuster or Case Manager Name:____________________ Date of Injury; ____/____/________

Emergency Contact: Name____________________________ Number_____________________

If Applicable:

Out of State Address: ____

City: _____________________________ State: _________ Zip Code:________________

PATIENT/GUARDIAN SIGNATURE_________________________________**DATE:**____________

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CONFIDENTIAL MEDICAL HISTORY FORM

NAME:____

Injury or Reason for Visit:____

When did Symptoms begin? _____________ Diagnostic Testing Done? ____________________

Have you received Therapy for this in past? Yes / No Any Therapy This Year? Yes / No

Surgery? Yes / No Date of Surgery? ____/_____/______

Hospitalization? Yes / No Date of Hospitalization? From:___/___/____ To: ___/___/____

Are you having Pain? Yes / No On a scale of 1 – 10 *(10 being emergency room pain)

What is your pain level at its worst? _________ At Current? ________ At its Best? _________

Are you receiving any Home Health Care? Yes / No Date of Discharge:_____/_____/______

FALLS: Have you fallen? Yes / No If Yes, Date of Last Fall: _____/_____/_______

Surgical History: ____

Medication List: or *(See Attached):____

____

*(When was list of medication(s) last revised by Primary Care Physician?) Date: ______/_____/_______

Do you Smoke? Yes / No Alcohol Consumption? _______/week Are you Pregnant? Yes / No

*Please check medical conditions you currently have or had in the past

	Asthma, Bronchitis, Emphysema			Arthritis, Swollen Joints			Shortness of Breath, Chest Pain
	Osteoporosis			Coronary Heart Disease			Varicose Veins
	Pace Maker			Gout			High Blood Pressure
	Sleeping Difficulties			Heart Attack, Surgery			Emotional, Psychological Problems
	Stroke/TIA			Bowel or Bladder Problems			Epilepsy/Seizures
	Severe/Frequent Headaches			Thyroid Trouble/Goiter			Vision/Hearing Difficulties
	Anemia			Dizziness or Faintness			Infectious Disease
	Cancer or Chemo/Radiation			Diabetes			

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Professional Physical Therapy and Associates

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Welcome to Professional Physical Therapy and Associates in Edgewater, Florida. We are committed to providing you with the best rehabilitative care. We want to make your visits to Professional Physical Therapy as productive and pleasant as possible. In order to do so, we must ask for a commitment on your part. The most important factor is scheduling and attending physical therapy on a regular basis. It is very important to follow your medical team's plan, which includes the frequency and duration, to reach your maximal potential. In an effort to provide you with the highest quality of care, our staff will adhere to the laws and regulations governing their respective licensed professions. Every effort will be made to meet your needs and make your rehabilitation a positive experience. If for any reason you feel your needs have not been met or your rehabilitative process has not been positive, please communicate your comments or concerns with the clinic manager in order for appropriate action to be taken according to Professional Physical Therapy's policy and procedures.

If for some reason you find it necessary to cancel a visit, please call us within 24 hours of your appointment at (386) 423-0100 to reschedule your appointment as there is a time on the schedule reserved specifically for you. If at all possible, the missed therapy appointment should be made up within the same week. Cancellations are sometimes unavoidable, however, in order to enforce this policy you will be charged $40.00 if you cancel an appointment less than 24 hours before your scheduled appointment time or if you do not attend a scheduled appointment. For your convenience, we are open Monday through Friday 7:00 am until 5:30 pm. Professional Physical Therapy is obligated to report all no-show and cancellations to your doctor and the involved insurance companies. Worker's Compensation patients must take extra precautions in attending physical therapy as treatment can be disrupted for non-compliance.

It is always the goal of Professional Physical Therapy to provide a professional and beneficial experience to the patient for whom we render service.

I, ____________________________, hereby agree and give my consent to receive medical treatment for my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment to **PROFESSIONAL PHYSICAL THERAPY AND ASSOCIATES LTD CO**, regardless of participation in or out of network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred. I acknowledge that I have received, read and understand the **NOTICE OF PRIVACY PRACTICES**.

PATIENT / GUARDIAN SIGNATURE: ______________________________ **DATE:** __________________