Islanders
PHYSICAL THERAPY
& Rehabilitation, Inc.

PATIENT INTAKE FORM

Date_____ Patient Name _____
(Last) (First) (MI)

Gender: M F Birthdate ____/____/____ Marital Status: Single Married

Mailing Address_____
(City) (State) (Zip)

Phone: Home_____ Cell_____ Work_____

Email Address_____

Would you like to have appointment reminder phone calls? Y N
Have you received Physical Therapy, Occupational Therapy or Speech Therapy services in the last 12 months? Y N If yes, when and where were the services received?
_____

Primary Insurance Co._____Subscriber ID_____
Subscriber Name _____DOB_____
Secondary Insurance Co._____Subscriber ID_____
Subscriber Name_____DOB_____

FOR L & I ~OR~ MOTOR VEHICLE ACCIDENT CLAIMS
Date of injury_____Claim #_____
Insurance Name_____
Claim Manager Name/Phone#_____
Employer Name_____Employer Phone#_____
Employer Address_____
(City) (State) (Zip)

I, _____, authorize Islanders Physical Therapy and Rehabilitation, Inc. to release any information regarding my medical history, symptoms and treatment to third party payers. A photocopy of this authorization shall be considered as effective and valid as the original. I understand I have the right to receive a copy of this authorization. (If a minor, signature of parent or legal guardian is required.) At this time I consent to physical/occupational/speech therapy treatment performed at Islanders Physical Therapy and Rehabilitation, Inc.. In addition I authorize payment of medical benefits to Islanders Physical Therapy and Rehabilitation, Inc., the supplier of services described above.

X_____**DATE**_____

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SUBJECTIVE REPORT/PMH FORM

NAME: _____ DOB: _____ DATE: _____

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

SUBJECTIVE HISTORY:

What is your date of injury/onset of symptoms? _____ When is your next physician's appointment? _____
How and where did you injure yourself? _____

Have you had any of the following?

☐ Bone scan	☐ Echocardiogram	☐ MRI	☐ Pulmonary Function Test
☐ CT scan	☐ EKG	☐ Myelogram	☐ Stress test
☐ Dopplar Ultrasound	☐ EMG	☐ NCV	☐ X-rays

Have you had any prior occurrences of this condition? ☐ No ☐ Yes
If yes, please explain: _____
Have you had any prior treatment for this condition? ☐ No ☐ Yes
If yes, please explain: _____

Are you pregnant or do you think you may be pregnant? ☐ N/A ☐ No ☐ YES

CURRENT COMPLAINTS:

What is your chief complaint? _____
What makes your symptoms better? _____
What makes your symptoms worse? _____

FUNCTIONAL/ADL RESTRICTIONS: OUTCOME MEASURE PROVIDED BY THERAPIST

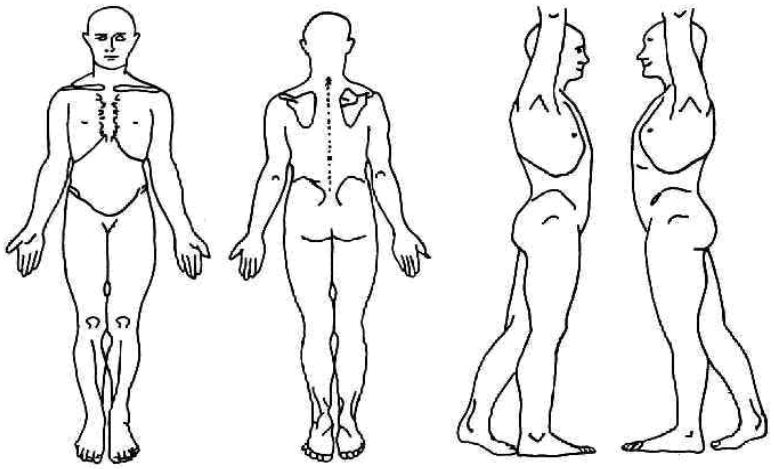
PRIOR LEVEL OF FUNCTION: What were you able to do prior to this injury that you are not able to do now? _____

PAIN RATING: 0 1 2 3 4 5 6 7 8 9 10

If you have pain, what is your pain level?
(0 = None, 5 = Moderate, 10 = Extreme)
Pain Level at WORST:_____
CURRENT Pain: _____
Pain Level at BEST: _____

Please describe what the pain feels like to you: _____
_____

Please mark the location of your pain with an X on the body chart to the right.



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SUBJECTIVE REPORT/PMH FORM

OCCUPATIONAL/WORK STATUS/EDUCATION:

What is your occupation? _____ Are you presently working: ☐ No ☐ Yes

If yes, ☐ full-duty ☐ limited duty Explain: _____

Lost days from work to date: _____ Days of work restriction to date: _____

Highest level of education completed:_____ Are you a Veteran? ☐ No ☐ Yes

SOCIAL HISTORY: Please check ☒ if appropriate.

Do you live: ☐ Alone ☐ With spouse/S.O. ☐ With family ☐ Other _____

Do you have stairs? ☐ No ☐ Yes If yes, how many? _____ Do stairs have handrails? ☐ No ☐ Yes

Do you have any home fall hazards such as throw rugs, poor lighting, etc? ☐ No ☐ Yes _____

How are your interests/hobbies affected by your symptoms? _____

Do you exercise? ☐ No ☐ Yes If yes, how often? _____

Do you smoke? ☐ No ☐ Yes If yes, how often? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, how often? _____

PAST MEDICAL HISTORY/GENERAL HEALTH: Please check ☒ all that apply.

☐ Allergies	☐ Chest pain	☐ Heart disease	☐ Night sweats
☐ Arthritis	☐ Chronic pain	☐ Hepatitis	☐ Osteoporosis
☐ Back/Neck pain	☐ Coughing up blood	☐ High blood pressure	☐ Productive cough
☐ Balance changes/dizziness	☐ Diabetes	☐ HIV/AIDS	☐ Rashes/skin
☐ Behavioral Health	☐ Epilepsy/Seizures	☐ Insomnia	☐ Staph infection
☐ Blood disorders	☐ Falls	☐ Irregular heart rate	☐ Stroke/TIA
☐ Bowel/bladder problems	☐ Fractures	☐ Memory loss	☐ Tuberculosis
☐ Breathing disorders	☐ Fevers/chills	☐ Metal implants	☐ Ulcers
☐ Cancer	☐ Headaches	☐ Nausea/vomiting	☐ Weight loss
☐ Chemical dependency	☐ Hearing loss	☐ Night pain	☐ Vision changes

HEIGHT _____ **WEIGHT** _____

Is there any other information regarding your medical history that we should know about? ☐ No ☐ Yes

If yes, please explain: _____

Current Medications: _____

Surgeries: _____

How would you classify your general health? ☐ Good ☐ Fair ☐ Poor

PATIENT'S GOALS:

What are your goals for participating in therapy? _____

_____

Are there any factors that may complicate your ability to participate in therapy? ☐ No ☐ Yes

If yes, please explain: _____

To the best of my knowledge, I have fully informed you of the history of my problem and current status.

Patient Signature: _____ Date: _____

Therapist Signature:_____ Date: _____

Islanders Physical Therapy & Rehabilitation, Inc.

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information
We use and disclose the information we collect from you only as allowed by the Health Insurance Portability Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone- even family members – without your written consent. You, of course, may give written authorization of us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so that you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information
We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information
As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages and answering machines.

Patient Rights
You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing.

We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

NOTICE OF PRIVACE PRACTICES- ACKNOWLEDGEMENT

We keep a record of the health care services we provide to you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Privacy officer or designee.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices

_____ _____

Patient or legally authorized individual signature **Date**

_____ _____

Printed Name **Relationship (parent/legal guardian, etc)**

This form will remain in your medical record file.

Form Updated 01/14/08

Office use only;

Patient refused to sign: _____
Staff initial

Islanders
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Cancellation and No Show Policy

Patient Name: _____Date: _____

Thank you for choosing **Islanders Physical Therapy and Rehabilitation, Inc.** to provide your therapy needs. Please read the following two policies, initial each one, and sign your name at the bottom of the page.

Cancellation Policy:

If you need to cancel a Therapy appointment, please call us ASAP (24 hours notice) so we have the opportunity to offer your appointment to another patient. If less than 24 hours notice is given you will be charged a $40 cancellation fee.
Initial_____

No Show Policy:

If you do not show up for a scheduled appointment you will be charged a $40 no show fee.
Initial_____

I understand the terms of this form. I realize that I am financially responsible for charges incurred from cancellations or no shows.

Patient Signature : _____

Parent Signature (If patient is a minor) _____