PATIENT INTAKE FORM

Today's Date Use 01/01/2016 format

Last Name:

First Name:

Middle Name:

Date of Birth:

Gender Male Female

Home Phone Number:

Cell Phone Number:

E-mail

Local Address:

City:

State:

ZIP Code:

If Permanent Address is the same leave blank.

Permanent Address:

City:

State:

ZIP Code:

MEDICAL HISTORY

Do you have or have you had any of the following diseases or problems?

Select all that apply.

Allergies	Anemia
Cancer	Circulatory
Depression	Diabetes
Fibromyalgia	Gout
Hearing Problems	Heart Disease
Hypertension	Hypotension
Immune system	Liver Disease
Mental Illness	Respiratory
Seizures	Stroke
Other	

Have you had any joint replacement surgeries? Yes No

Have you had any joint fusions? Yes No

Select the type of replacement

- Left Shoulder
- Right Shoulder
- Left Hip
- Right Hip
- Left Knee
- Right Knee

Select type of fusion

- Cervical
- Lumbar
- Other

Do you have a Pacemaker? Yes No

Do you have any other surgically implanted devices? Yes No

List other devices

Have you fallen is the last year Yes No

MEDICATION & SUPPLEMENTATION HISTORY

Please select from the drop down menu prescriptions medications, over the counter or vitamins you may be taking currently. If your medications are not listed please type them in the blank spaces below the 5 drop down menus.

----------------------------Medications/Vitamins------------------Dosage ----------------Frequency---------------------

If medication is not listed in drop down, move to next section and type in blank spaces

DROP DOWN

Medications/Vitamins Dosage Frequency

TYPE

Medications/Vitamins Dosage Frequency

Not currently taking any Medications or Supplements

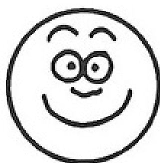
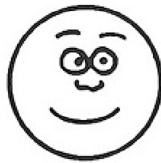
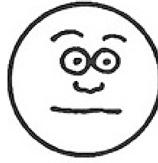
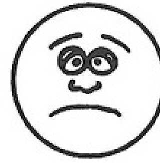
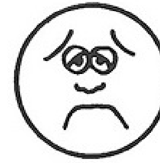
REASON FOR VISIT

Where is the chief complaint for today's visit?

Select all that apply:

- Neck and Back Pain
- Shoulder Pain
- Elbow Pain
- Wrist Pain
- Low Back Pain
- Mid Back Pain
- Hip Pain
- Knee Pain
- Ankle Pain
- Foot Pain
- Gait and or Balance
- Swelling
- Tingling In Arms
- Tingling In Legs

Current Pain Assessment

0 No Hurt | 2 Hurts Little Bit | 4 Hurts Little More | 6 Hurts Even More | 8 Hurts Whole Lot | 10 Hurts Worst

	0 No Hurt	2 Hurts Little Bit	4 Hurts Little More	6 Hurts Even More	8 Hurts Whole Lot	10 Hurts Worst
Select One						

Discloser and Consent Agreement

I hereby indicate my wish to be a participant in the rehabilitation program formulated and established by Brett Richman (RPT) and with implementation and execution by the former and by the Fairway Physical Therapy staff. I verify my participation is fully voluntary, no coercion of any sort to obtain my participation and I may withdraw from treatment at anytime. I also understand that changes may occur during my treatment, which could necessitate a re-evaluation by the referring MD, Brett Richman (RPT), or if necessary the discontinuation of therapy.

By clicking **Yes** you consent to all the above mentioned.

Yes No

Insurance and Patient Release Authorization

I hereby authorize payment directly to Fairway Physical Therapy for the benefit due to me in my pending claim and/ or Major Medical Benefits otherwise payable to me, but not to exceed the physicians and/or the facilities regular charges for therapy for this treatment period. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for the charges not covered by this authorization. A copy of this authorization may be used in lieu of the original.

By clicking Yes you consent to all the above mentioned.

Yes No

Privacy Practices

Fairway Physical Therapy reserves the right to modify the privacy practices outlined in the notice. I have read a copy of the the Notice of Privacy Practices for fairway Physical Therapy.

(See at bottom of form for Privacy Practices Discloser Form)

By clicking Yes you consent to all the above mentioned

Yes No

Patient signature (or person completing for patient)

Fairway Physical Therapy

Notice of Privacy Practices

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of any testing in physical therapy will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Fairway Physical Therapy. For example, information on the service you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support governmental audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information: Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information About Treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.

Individual Rights: You have certain rights under the federal privacy standards. These include:

- The right to request restriction on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.

Fairway Physical Therapy's Duties:
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices that are outlined in this notice.

Right to Revise Privacy Practices:
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in the federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all health information we maintain.

Requests to Inspect Protected Health Information:
You may generally inspect or copy the protected health information we maintain. As permitted by federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Receptionist or the Office Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints:
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter to:

Brett Richman
Fairway Physical Therapy
7100 Fairway Drive Suite #27
Palm Beach Gardens, Florida 33418
(561) 775-7775

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.
Effective Date 06/24/15

Please inform secretary that you are now finished with intake form.