Limitless Physical Therapy

Patient Intake Information

Welcome to Limitless Physical Therapy. Our Physical Therapists and staff take pride in providing you individualized care and impeccable customer service. To best serve you, we need to gather some information about you. If you have any questions, please ask.

Name: _____ Date: _____

Height: _____ Weight: _____

WHAT BRINGS YOU IN?

Injury/Condition: _____ What date did your symptoms begin? _____

What caused your injury/condition? _____

How does this condition limit your movement or wellbeing? _____

Have you seen another provider for this problem **Y** **N** If yes, when? _____

Have you had imaging done for this problem? **Y** **N** If yes, what kind? _____

Have you had any surgery or procedure done to address this problem? **Y** **N**

If yes, describe: _____

TELL US ABOUT YOUR PAIN…

My pain is like **(Circle all that apply)**:

numbness sharp dull achy

burning tingling throbbing

I feel this pain **(Circle all that apply)**:

constantly intermittently inconsistently

Rate your pain level **0 - 10 (0 = No Pain; 10 = Severe Pain)**:

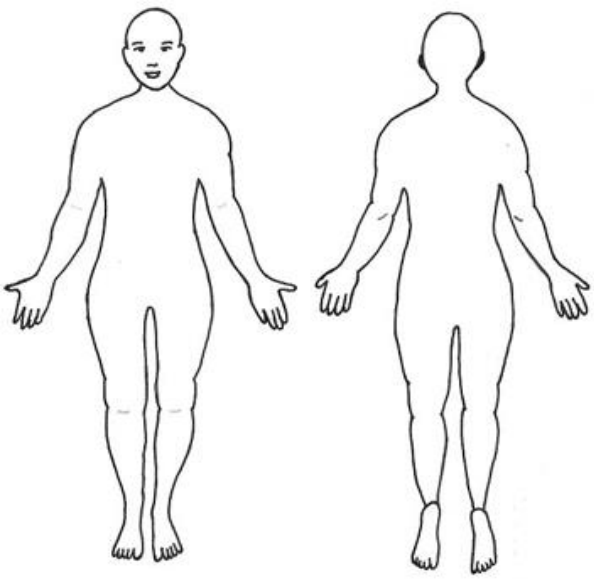
Currently: _____ At its best: _____ At its worst: _____

What Movements or activities make your condition worse?

_____

_____

Mark where you have pain



GOALS

List 3 activities you are limited in currently? **Rate the difficulty 0 - 10 (0 = Cannot do at all; 10 = No difficulty)**

1. _____
2. _____
3. _____

HEALTH HISTORY

Please list all medications you are currently taking (If more than 3 ask us for a med sheet): _____

_____

Is this injury the result of a fall? **Y N**

Have you fallen in the past year? **Y N** If yes, how many times? _____

Have you recently had any of the following? **(Circle all that apply):**

Bladder Difficulties	Bowel Difficulties	Breathing Difficulty	Insomnia	Weakness
Change in Vision	Nausea/Vomiting	Weight Loss	Fatigue	Fever/Chills/Sweats
Pain at night	Pregnancy			

Do you currently have or have had any of the following? **(Circle all that apply):**

Allergies/Skin Sensitivity	Anxiety	Asthma/Breathing Problems	Autoimmune Deficiency
Cancer	Circulation Problems	Depression	Diabetes
Easy bruising/bleeding	Fainting	Fractures	Heart Problems
Hepatitis	High Blood Pressure	Indigestion/Heartburn	Kidney Disease
Leg/Ankle Swelling	Loss of consciousness	Lung Disease	Metal Implant
Motor Vehicle Accident	Multiple Sclerosis	Osteoporosis/Osteopenia	Pacemaker
Smoking	Sprains/Strains	Stroke	Surgeries
Thyroid Problems	Urinary Problems/Infections		

At the current time would you rate your overall health as **(Circle one)**:

Excellent Very Good Good Fair Poor

PERSONAL INFORMATION

Name: Last _____ First _____ Middle _____

Preferred _____ DOB: _____ Gender: M F

Address: _____

Ph #: _____ Cell/Home/Work (circle): **OK TO LEAVE MESSAGES? (Circle one): YES NO**

Alt. Ph #: _____Cell/Home/Work (circle): **OK TO LEAVE MESSAGES? (Circle one): YES NO**

Email: _____

I prefer appointment reminders via **(Circle one)**: Text Email Phone Call

If text, my cell carrier is: _____ (Please note that standard text messaging rates may apply)

Emergency Contact: _____ Ph #: _____ Relationship: _____

Physician's Name: _____ Clinic: _____

Other Current Healthcare Provider: _____ Clinic: _____

How did you hear about us?

☐ Referring Provider ☐ Friend/Family ☐ Radio

☐ Facebook ☐ Online ☐ Other _____

INSURANCE INFORMATION

Are you the primary subscriber on the plan?: **YES** **NO**

If you are **NOT** the primary subscriber, please complete:

Subscriber (primary on plan) exactly as it appears on card: _____

Member ID#: _____ Group #: _____ Policy #: _____

Subscriber's DOB: _____ Subscriber Gender: M F Subscriber Ph #:_____

Subscriber's Address: _____

Responsible Party: _____

Claim # (If Worker's Compensation or Auto Accident): _____

State where accident/injury occurred: _____

If responsible party is someone other than yourself or the subscriber, please provide the following:

Name: _____ Relationship to patient: _____ Responsible Party's DOB: _____

Ph #: _____ Address: _____

Please read the information below carefully and let us know if you have any questions or concerns.

You are voluntarily consenting to evaluation and treatment by Limitless Physical Therapy. You have the right to decline any procedures after discussing the risks and benefits with your physical therapist.

We request 24 hours notice when cancelling appointments. If you fail to provide 24 hours notice and we cannot reschedule your appointment during the following business day, you will be charged a $40.00 fee.

We will verify your insurance benefits as a courtesy to you and will communicate that information to you, but you understand that this information is not a guarantee of payment. You authorize Limitless Physical Therapy to communicate with your insurance company in order to collect payment for the services provided to you, unless you have chosen to pay for services out of pocket. You are responsible for payment at the time of service. Depending on your insurance benefits, or if you are paying out of pocket for services, you are responsible for the applicable co-pays, co-insurance, payment toward your deductible or payment for the cost of each visit. You must make a payment each visit unless prior arrangements have been made with Limitless Physical Therapy.

Phone calls to the main clinic line (541) 704-7770, and faxes to the clinic fax number (541) 704-7773 are the only secure means to contact Limitless Physical Therapy. If you choose to contact the clinic or physical therapist via other means, including but not limited to Facebook message, email, or personal phone number, your personal information cannot be secured.

We have provided you a copy of our HIPAA-Privacy Policy, additional copies can be made available to you upon request.

*By signing, you agree to all the above. If you have questions or concerns, please return to the front desk and discuss with one of our Customer Service Specialists prior to signing.

Signature: _____ Date: _____