



TRUE Physical Therapy PA  
2081 N Webb Rd.  
Wichita KS, 67206  
(316)260-8239

### Patient Intake Form

Patient's Name \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
DOB: \_\_\_\_\_ SS #: \_\_\_\_\_ M/F: \_\_\_\_\_  
Injury from Accident? Y N If so, date: \_\_\_\_\_ Auto Work Other  
Friend/Relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Spouse: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Referring Doctor: \_\_\_\_\_ Primary Doctor: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance ID # \_\_\_\_\_  
Plan # \_\_\_\_\_ Policy Holders Name \_\_\_\_\_



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Medical Screening Form

Patient Information: Date:
Patient Name: DOB:
Current Diagnosis: Date of Injury:
Currently: (please circle one) Working Not working Retired Other
Occupation:
Primary Care Physician:
Do you have beliefs that may affect your care? Yes No
How did you hear about us? Walk-in Word of Mouth Referral Advertising Other

History:
Do you exercise regularly: Yes No Type of exercise:
Tobacco Use: Never I quit I still smoke Smokeless Tobacco
Please rate your general health: Excellent Good Fair Poor
Have you had any major life changes recently: Yes No
Do you have any allergies: Yes No
If yes, explain:
Are you, or is there a chance you are pregnant? Yes No
Do you have a pacemaker or any implanted device? Yes No
If yes, explain:
Please list any barriers to communication or anything else you feel is important:
Please list any health problems or surgeries:

Currently I am experiencing the following:
Unexplained Weight Loss Difficulty Swallowing Dizziness
Changes in Bowel/Bladder Headaches Depression
Fever/Chills/Sweats Nausea / Vomiting Shortness of Breath
Changes in Appetite Numbness /Tingling Poor Balance / Falls
Other:

Medications:
Please list all:

Current Condition:

Where are you currently having symptoms? \_\_\_\_\_

When did this begin? \_\_\_\_\_

How did this occur? \_\_\_\_\_

Have you experienced these symptoms before?  Yes  No

Please list any treatment you have received for this injury: \_\_\_\_\_

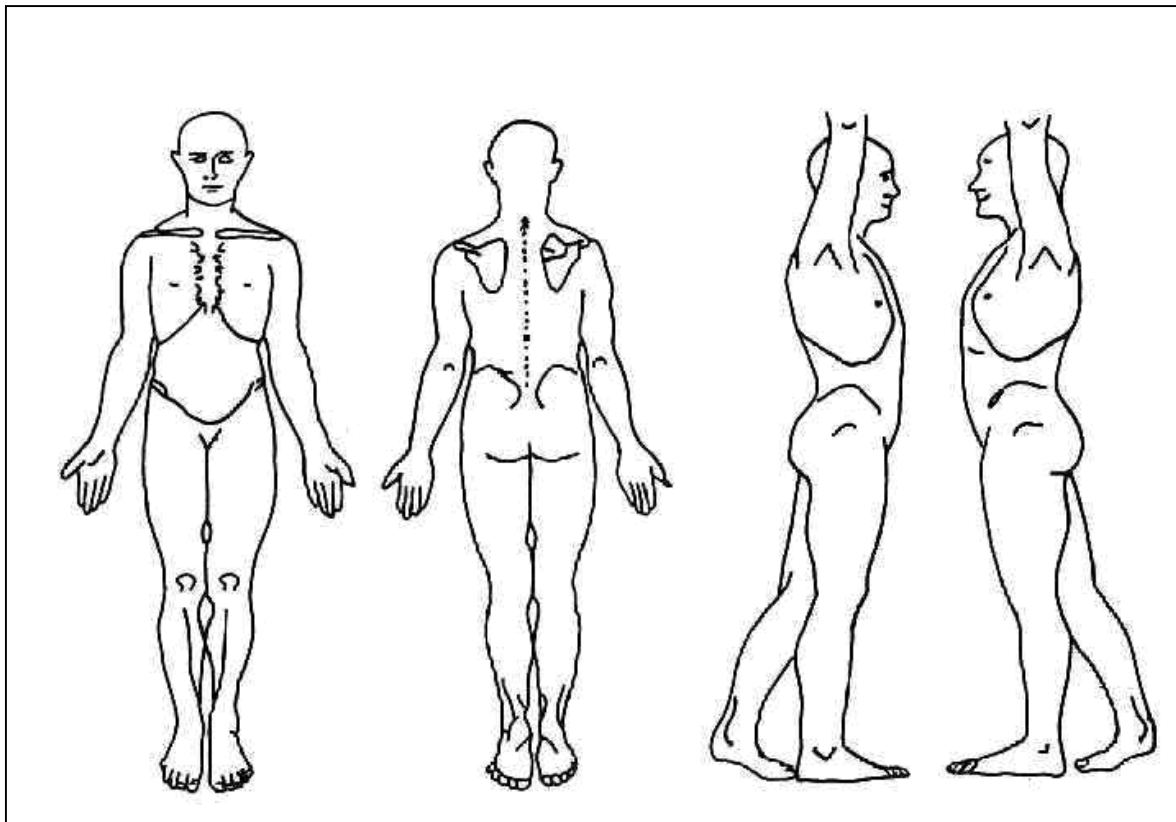
Have you had any imaging? (MRI, Xray, etc) If so explain? \_\_\_\_\_

Are you current symptoms getting better, worse or staying same? \_\_\_\_\_

Please rate your pain on the following scale: 0(no pain) - 10 (worst pain)

Currently: \_\_\_\_\_ Best: \_\_\_\_\_ Worst: \_\_\_\_\_

Please mark your area of pain on the following body chart:



What are your physical therapy and/or fitness goals?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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**Consent to Treat / Privacy Policy**

Printed Name \_\_\_\_\_

1. I hereby give TRUE Physical Therapy P.A. consent to treat my prescribed injury.
2. I hereby acknowledge that I understand TRUE Physical Therapy's Notice of Privacy Practices and HIPAA.

3. I give TRUE Physical Therapy P.A consent to release medical information and/or insurance information to the people listed below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

4. I give TRUE Physical Therapy P.A. permission to leave phone messages regarding my physical therapy care at the number listed below. This consent will remain valid until revoked in writing.

Cell # \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

**Financial Policies**

1. I agree to pay for equipment and supplies not covered by the contract between TRUE Physical Therapy P.A. and my insurance company.
2. Estimated payment is required at the time of service. This includes, but not limited to all copayments, co-insurance, and deductibles. Office Manager must approve payment arrangements.
3. Unaccompanied Minors - Parents (or guardians) are responsible for co-payments, deductibles, and non-covered amounts at each visit.
4. We respectfully ask you to give us as much notice as possible. Unless an appointment is cancelled at least 24 hours in advance, you may be subject to a \$30 fee.
5. Overpayments will be refunded to the responsible party within 30 days upon written request.
6. I agree to pay \$35 for any returned checks in addition to the amount of the check that have been returned within 5 days of the check being returned.

**Assignment of Benefits/Medical Release:** I authorize TRUE Physical Therapy P.A. to accept payments of medical benefits for the services they provide. I understand that I am responsible for any amount not covered by insurance and it is my responsibility to know my copays, deductibles, out of pocket amounts, etc., which have been established through my individual insurance policy. I authorize release of any medical information necessary to process this claim and all future claims.

Signature \_\_\_\_\_ Date \_\_\_\_\_