TRUE Physical Therapy PA
1819 N Greenwich Ste A
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

Emergency Contact:_____Phone:_____

Are you apart of a group/organization that would benefit from our services?

N/Y: If yes, where: _____

Employer:_____Phone:_____

Address:_____

City/State/Zip:_____

Spouse:_____Phone:_____

Address:_____

City/State/Zip:_____

Referring Doctor:_____ Primary Doctor:_____

Insurance Company:_____ Insurance ID #_____

Plan #_____ Policy Holders Name _____

Policy Holders DOB:_____ Relationship to patient:_____

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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 Dr. Referral Advertising Other
Who can we thank for telling you about us? _____

History:
Do you exercise regularly: □Yes □No Type of exercise: _____
Height:_____ Weight: _____
Tobacco Use: □ Never □ I quit □ I still smoke □ Smokeless Tobacco
Alcohol Use: □ Yes □ No
If Yes, How Often: □ Daily □ Weekly □ Monthly □ Other_____
Any falls in the last year: □ Yes □ No If yes, how many? _____
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 with dosage, frequency and route taken (orally, topical, etc.)
_____
_____
_____
_____

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Current Condition: Patient Name: _____

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? _____

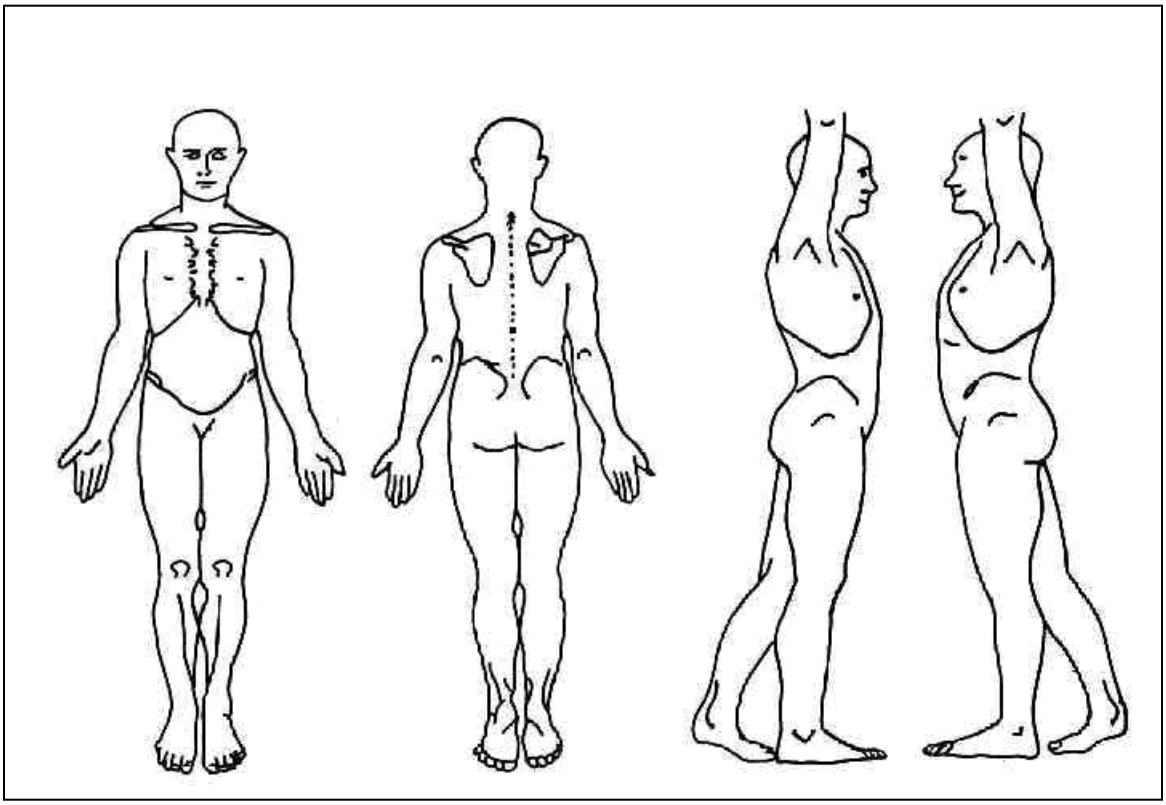
_____

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. If you are more than 10 minutes late to your scheduled time, then you may be asked to reschedule your appointment.
5. 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 $50 fee.***
6. Overpayments will be refunded to the responsible party within 30 days upon written request.
7. I agree to pay $50 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 _____