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 Referral Advertising Other

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? __________________

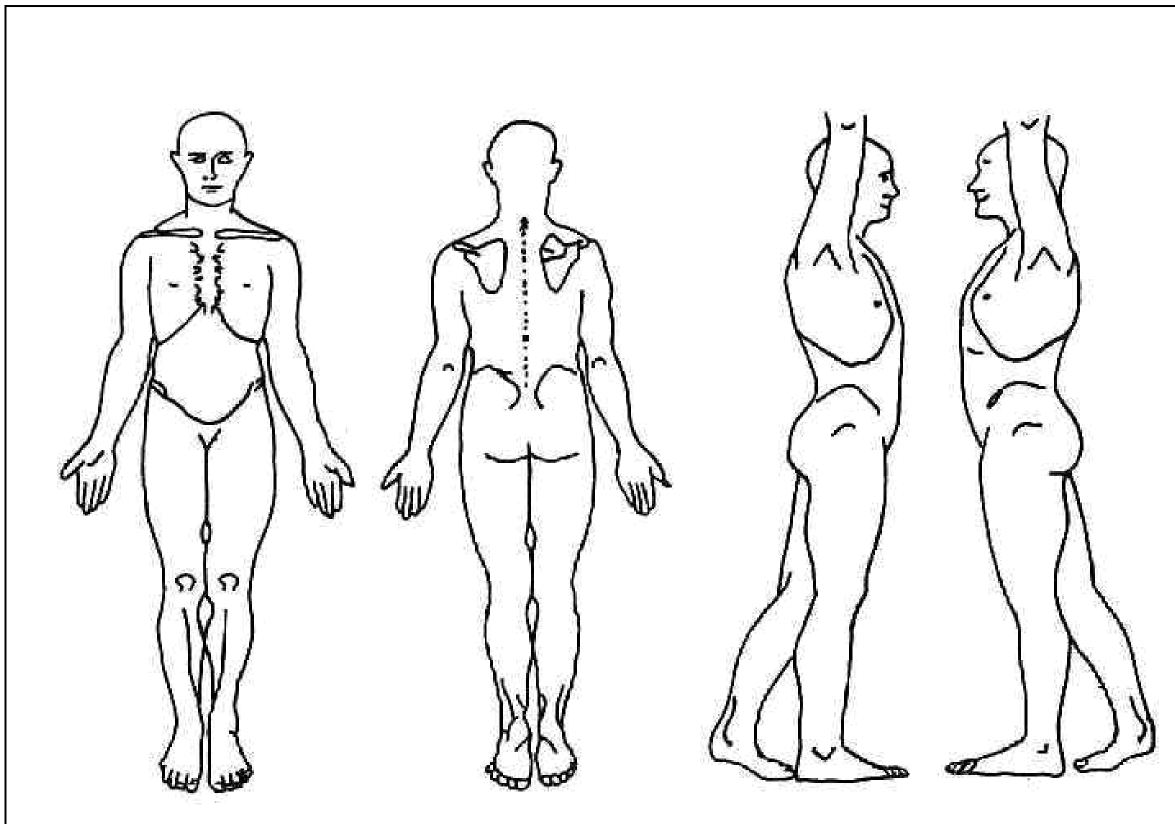
____

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 ________________