



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: _____
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: _____



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: _____

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: _____

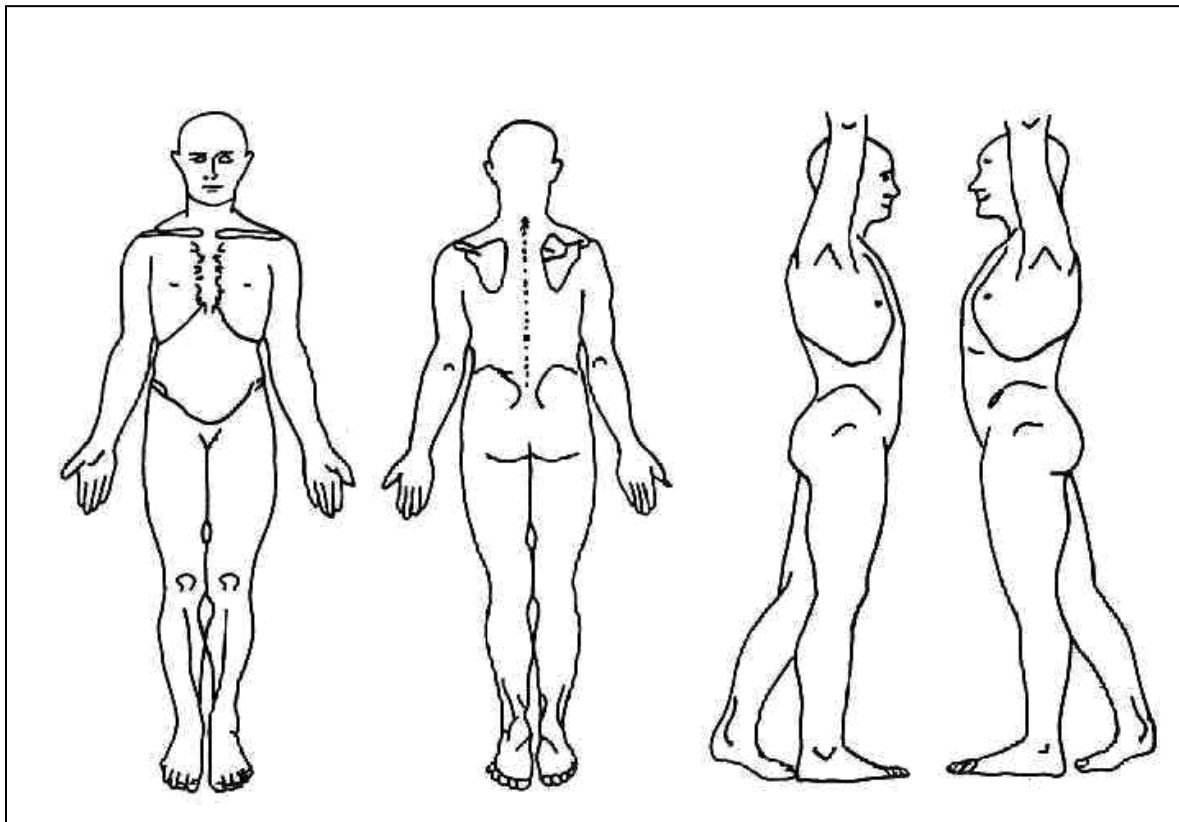
Have you had any imaging? (MRI, Xray, etc) If so explain? _____

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. 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 \$30 fee.
6. Overpayments will be refunded to the responsible party within 30 days upon written request.
7. 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 _____