Active Physical Therapy & Associates
1423 N. & 101 S. Tracy Blvd.
Tracy, CA 95376

Patient Intake Form

Patient Name _____ E-Mail Address _____

Address _____ City, St, Zip _____ Sex M/F _____

Home Phone # _____ Cell # _____

Preferred Method for Appointment Reminders ____ Text ___ E-mail ___ Phone Call

Cell Phone Provider (for text message reminders)_____

Birth Date ____-____-____ Age _____ Social Security # _____

Marital Status _____ Spouse _____

Spouse Birth Date ____-____-____ Spouse Social Security # _____

Emergency Contact _____

Billing Information

Private Health Insurance ____ Auto ____ Worker's Compensation ____

Cash ____ Medicare ____

If work or auto related date of injury _____ Currently Working? Y / N

If injury, how did injury occur? _____

BENEFITS, MEDICAL AND AUTHORIZATION FOR TREATMENT: I AUTHORIZE THAT PAYMENT OF MEDICAL BENEFITS SHALL BE PAID DIRECTLY TO **ACTIVE PHYSICAL THERAPY & ASSOCIATES.** I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT **NOT** COVERED BY INSURANCE CARRIER. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM. I HEREBY **AUTHORIZE THIS OFFICE TO BEGIN TREATMENT** AS PRESCRIBED BY MY PHYSICIAN. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS, INSURANCE, OR INFORMATION ON THE REGISTRATION FORMS.

There will be a **$25 charge** to the patient for **"no show"** appointments and cancellations **without 24 hour advance notice.** This applies to **all patients,** private insurance, workers compensation, auto, etc. Emergency situations will be considered.

_____ _____
SIGNATURE DATE

_____ _____
PARENT SIGNATURE (IF PATIENT IS A MINOR) DATE

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INSURANCE COVERAGE & FINANCIAL RESPONSIBILITY

Deductibles and co-payments are due at the time services are rendered. Our office allows 45 days for insurance claims settlement. However, for payments not received from insurance carriers in this time frame, you, the patient, are responsible for payment in full.

We will gladly discuss your treatment and answer any questions relating to you insurance. However, you must realize that:

1. Not all services are a covered benefit in all contracts. You are responsible for charges not covered by your insurance. Insurance carriers will sometimes quote benefits and then deem your treatment as "not medically necessary" by their standards. Any denied benefit will be your financial responsibility.
2. We emphasize that your insurance plan is a contract between you and/or your employer and the insurance company. **IT IS YOUR RESPONSIBILITY TO KNOW YOUR BENEFITS FOR PHYSICAL THERAPY.**

PRIVACY ACKNOWLEDGEMENT/ AGREEMENT

A written notice of privacy rights is posted in the waiting room of ACPT, and I understand that I may receive a copy of these rights upon my request. I consent to ACPT using and disclosing my protected health information to carry out treatment payment or healthcare operations.

If you have any questions in regards to our policies and your insurance coverage, please do not hesitate to ask us. We are here to assist you.

_____

PLEASE SIGN THAT YOU HAVE READ AND AGREE TO THE TERMS OF THIS AGREEMENT

Active Physical Therapy & Associates

HEALTH HISTORY
(Confidential)

Date _____

Name _____ Age _____ Date of Birth _____

Injury/Problem area_____

Grade Intensity/Severity of Pain

(No pain/no complaint) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint)

Check any medical conditions you currently have or have experienced in the past:

- ❑ Arthritis (rheumatoid/osteoarthritis)
- ❑ Osteoporosis
- ❑ Stroke/TIA
- ❑ Depression
- ❑ High blood pressure
- ❑ Heart attack (Myocardial infarction)
- ❑ Visual Impairments
- ❑ Diabetes
- ❑ Respiratory conditions (Asthma, COPD, etc...)
- ❑ Cancer
- ❑ Headaches
- ❑ Other_____

How freqently to you experience pain or discomfort associated with the injury/problem area?

- ❑ Hourly
- ❑ Daily
- ❑ A few times a week
- ❑ Once a week
- ❑ Less than once a week

How would you describe the pain? (mark all that apply)

- ❑ Constant
- ❑ Intermittent
- ❑ Occasional
- ❑ Ache
- ❑ Sharp
- ❑ Burning
- ❑ Pins and Needles
- ❑ Tingling/Numbness (where)_____
- ❑ Other_____

Please mark activities that aggravate the injury/problem area: (mark all that apply)

- ❑ Sitting
- ❑ Standing
- ❑ Walking
- ❑ Running
- ❑ Lying down
- ❑ Squatting
- ❑ Bending
- ❑ Turning
- ❑ Lifting
- ❑ Reaching overhead
- ❑ Typing (computer work)
- ❑ Other_____

Please mark activities that provide relief to the injury/problem area: (mark all that apply)

- ❑ Sitting
- ❑ Standing
- ❑ Walking
- ❑ Lying down
- ❑ Applying heat
- ❑ Applying ice
- ❑ Elevating the injury/body part
- ❑ Other_____

Please indicate your current **maximum ability** to perform the following tasks:

Sit (time):_____
Stand/Walk (time):_____
Run (time): _____
Stairs (#):_____
Lift (lbs):_____
Push/Pull (lbs):_____
Reach (reps or time):_____
Squat (reps):_____

Please list current medications you are taking:_____
_____

Please list previous surgeries (include dates):_____
_____

PLEASE MARK AN "X" ON THE BODY DIAGRAM WHERE YOU ARE HAVING PAIN: