FOOTHILLS Physical Therapy

Boise: 1673 W. Shoreline Drive, Suite 230, 83702 ♦
(208) 343-4700, Fax: (208) 343-4706
Meridian: 1618 S. Millennium Way, Suite 210, 83642 ♦
(208) 884-4647, Fax: (208) 884-8984
Eagle: 645 E. State Street, Suite 101, 83616 ♦
(208) 939-9594, Fax: (208) 939-9828
foothillspt.com

PATIENT INTAKE

Appointment Date:
Therapist:

Personal Information
Patient Name
Nickname(s) or Preferred Name
Home Address
City, State, Zip Code
Home Phone #
Work Phone #
Cellular Phone #
Date of Birth Age
Social Security Number (SSN)
Sex: M or F
Employer
Employer Address
City, State, Zip Code
Occupation
Marital Status M S D W
Emergency Contact: Name and Phone #
Email Address:

POLICY HOLDER/RESPONSIBLE PARTY INFORMATION	
Name (last/first/m)	
Address	
City, State & Zip Code	
Phone #	
Work #	
Cell #	
Gender	Male Female
Social Security # (SSN)	
Employer	
Date of Birth	
Occupation	
Relationship to Patient(circle)	Self Spouse Parent Other

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PATIENT HISTORY FORM

Patient Name: _____
Date of Birth: _____

Current Conditions/Chief Complaint: _____
_____
_____

Describe the problem for which you seek physical therapy: _____
_____
_____

When did the problem begin? _____
What happened? _____
_____

Have you ever had this problem before? If yes, explain. _____
_____
_____

What aggravates or makes your problem worse? _____
_____

What eases or makes your problem better? _____
_____

What are you currently doing to make your problem better? _____
_____

What are your goals for physical therapy? _____
_____

Functionally, what are you having difficulty with?
(For example: driving, walking, prolonged sitting, lifting, working….) _____
_____
_____

Current Medication (please list all): _____
_____
_____

Are you allergic to any medications? (please list all): _____
_____

Please Complete Next Page

Medical History: _____
_____
_____
_____

Surgical History: _____
_____
_____
_____

Are you experiencing any of the following?

1. Fever/chills/sweats
2. Nausea/vomiting
3. Dyspnea (difficulty breathing)
4. Recent onset of weakness
5. Syncope/dizziness
6. recent change in bowel or bladder control

Functional / Social Questions:

Are you currently working? Y N

Full duty, no limitations? Y N

If not working, how long have you been out of work?
_____

-Difficulty with self-care? Y N
-Difficulty with home management (as shopping, care of dependents, chores)?
Y N
-Difficulty with work activities? Y N

With whom do you live? (circle)
Alone, Spouse, Group setting, Caregiver, Child(ren), Other_____
Do you feel you need social services/counseling for any of these concerns? Y N

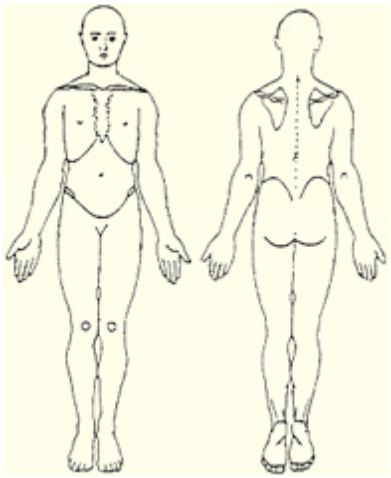
Have you undergone any diagnostic testing for this problem (x-rays, MRI, CT Scan, EMG, ect.)?
_____
_____

please refer to the Pain Intensity Scale to answer the following questions.

At Best ☐ At Worst ☐ Average ☐ At This Moment ☐

Pain Intensity Scale	
0	No Pain
1	Low: No pain medications. Normal levels of activity, except for heavy types.
2	
3	
4	Moderate: Regular use of pain medications and possibly muscle relaxants. Activity is very limited, but functional for family & social roles.
5	
6	
7	High: Regular use of pain, anti-inflammatory & muscle relaxant medication. Activity limited to necessary self-care.
8	
9	
10	Emergency Situation

Please mark on the body chart the site(s) of pain for which you are seeking physical therapy.



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OUTPATIENT SERVICES CONSENT FOR TREATMENT

Please read carefully

Consent for Treatment: I authorize the staff at Foothills Physical Therapy to undertake such treatment and procedures as deemed appropriate to improve my condition. It is recognized that the practice of medicine is not an exact science and, as such, no guarantees are made by the staff of Foothills Physical Therapy as to the results of treatment or interventions performed. I am advised that I have the full right to a full explanation of any treatment or procedure utilized. I understand that I have the right to refuse treatment; but, in doing so, I also understand that the desired outcome of my treatment program may by affected. Persistent refusal to participate or cooperate in the recommended treatment program may result in my discharge from the program. _____
(INT)

Personal Property: It is understood that Foothills Physical Therapy shall not be liable for loss or damage to any personal items brought to Foothills Physical Therapy during your course of treatment. _____
(INT)

Release of Information: Foothills Physical Therapy may disclose all or any part of my records to any party or organization responsible for all or part of my therapy charges. Foothills Physical Therapy may disclose all or part of my record to other health care providers including but not limited to, hospitals and physicians. I further agree that Foothills Physical Therapy may release all or any part of my record to any federal, state, or local government body when, in the opinion of Foothills Physical Therapy such bodies may be liable for all or part of my charges in relation to my care and treatment pursuant to statute or rule. _____
(INT)

Financial Consent: I agree to be responsible for payment of all outpatient physical therapy charges which are not covered by insurance, and when appropriate, to submit applications to federal, state, and county programs. I understand Foothills Physical Therapy will bill me, my family, and/or other responsible parties for services provided. _____
(INT)

Assignment of Insurance Billing: I and/or the responsible party voluntarily assign Foothills Physical Therapy and its independent contracting providers the right to pursue their respective claims for reimbursement from any insurance policy or policies providing coverage for services provided.

_____
(INT)

Notice of Privacy Practices: I hereby acknowledge that I have received a copy of Foothills Physical Therapy's Notice of Privacy Practices on this day. _____
(INT)

(Please complete back side)

<u>CANCELLATION & NO SHOW POLICY:</u> Foothills Physical Therapy is founded upon, one-on-one, quality care. We are dedicated to providing an empowering environment with individualized care to achieve optimal healing and functional recovery for our patients. In keeping with our mission we ask that our patient be adherent to their scheduled physical therapy appointments.

If you should have to cancel an appointment, we kindly request **<u>at least</u> 24 business hours notice.** For patients who do not provide **<u>at least</u> 24 business hours advance notice**, if we feel it is necessary we will charge you a **$35 fee**. _____
(INT)

Repeated cancellations and/or not showing up to appointments **<u>do not</u>** align with the Foothills Physical Therapy mission. Please be advised if you cancel **<u>and/or</u>** no show for **3** physical therapy appointments your therapist may discharge you from care and send your referring provider a note regarding your non-adherence to your therapy plan of care. _____
(INT)

Signed _____ Date _____
(patient/representative)

Witness _____

If you have any questions please ask the front desk. Thank you, Foothills Physical Therapy.