

Merrimack Valley Physical Therapy

Personal Injury Intake Form

Patient Information

Date: _____ Date of Birth: ___/___/___
Name: _____ Social Security: ___-___-___
Address: _____
Street City State Zip
Email Address: _____
Home Phone: _____ Cell Phone: _____
Gender: _____ Height: _____" Weight: _____ lbs
Marital Status: _____ Number of Children: _____
Employer: _____ Occupation: _____ Work Phone: _____
Employer Address: _____
Street City State Zip
Attorney: _____ Phone: _____
Emergency Contact: _____ Relation: _____
Emergency Contact Phone Number: _____
If under 18 years, name of Parent or Guardian: _____
PCP Name: _____ Phone: _____
How did you hear about our office ? Website Gym member Walk in Yellow
pages Friend/Former patient _____ Doctor _____
 Other _____

Accident Information

Date: _____ Time: _____ AM PM Was it reported? YES NO
Town accident occurred in: _____ Street: _____
Please explain in detail how the accident occurred: _____

Please list symptoms felt immediately after the accident: _____

Were you in a work vehicle at the time of the accident? YES NO
Were you the DRIVER FRONT SEAT PASSENGER BACK SEAT PASSENGER?
Were you wearing a seat belt? SHOULDER HARNESS LAP HARNESS
Where were you taken after the accident? _____
If hospital, how were you taken? AMBULANCE PRIVATE VEHICLE OTHER
Were X-Rays done? YES NO An MRI? YES NO CAT scan? YES NO
Have you seen any other doctor(s) since the accident? YES Name _____ NO
Have you missed any work since the accident? YES NO Date(s) _____
Did you ever experience similar symptoms prior to the accident? YES NO
Has your condition IMPROVED WORSENER or STAYED SAME since the accident?
Please share any other information that might be important to your diagnosis and
treatment: _____

Patient Signature (Parent/Guardian or Minor): _____ Date: _____

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Medical History Form

Name: _____ DOB: ___/___/___ Today's Date: ___/___/___

Occupation: _____ Gender: _____ PCP: _____

Referring Physician (MD): _____ Next appointment w/ referring MD: ___/___/___

Please answer the following questions:

What injury or condition brings you here today? _____

When did you first notice your condition (date of onset)? _____

How did this injury occur? _____

Is your condition due to a motor vehicle accident? Yes No If yes, date of accident? _____

Have you had any falls in the past 12 months? Yes No If yes, how many times? _____

Did the fall(s) result in injury? Yes No If yes, please describe: _____

Please describe above: _____

Are you seeing (or have you been seen by) any other specialists for your current condition (e.g.: doctor, psychologist, chiropractor, physical therapist, etc.)? Please list: _____

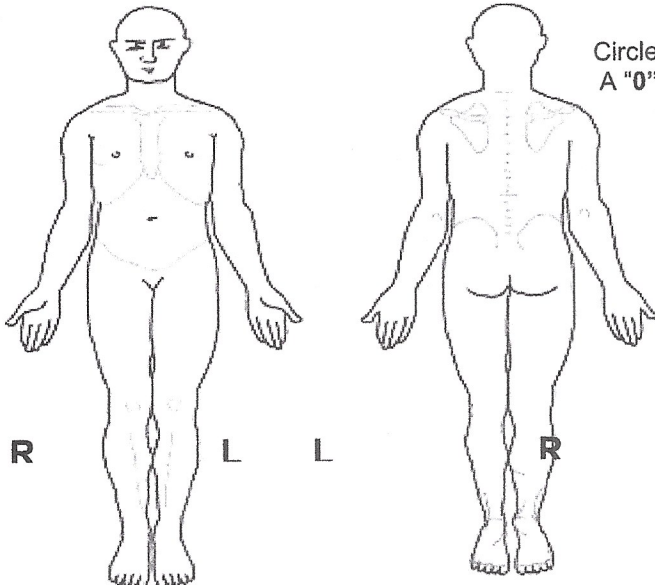
Have you been treated by another physical therapist/chiropractor in the past for this or any other condition?
 Yes No

If Yes, by whom/when? _____

What tests have you had for this condition? X-ray MRI CT scan Other: _____

Please mark where you have symptoms on the picture below.

Sharp Pain: ////////////// Achy Pain: ^^^^^ Burning Pain: XXXXX Numbness: 0000



Circle the number corresponding with the intensity of your symptoms.
A "0" = No Pain where as a "10" = most severe pain imaginable.

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Since this condition began your symptoms have: decreased not changed increased

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Since this condition began your symptoms have: decreased not changed increased

Your symptoms are worse in the: morning afternoon night same all day

What are your goals for treatment? _____

Please list past surgeries/conditions/hospitalizations:

_____/_____/_____
_____/_____/_____

Please list all medications, dosage, frequency and route (or you may attach a separate list):

Name: _____ Dosage: _____ Frequency: _____ Route: _____
Name: _____ Dosage: _____ Frequency: _____ Route: _____
Name: _____ Dosage: _____ Frequency: _____ Route: _____

Have you ever been diagnosed and/or treated for any of the following conditions (circle all that apply):

CONSTITUTIONAL

Weight Loss
Fatigue
Fever

EYES

Glasses/Contacts
Eye Pain
Double Vision
Cataracts

CARDIOVASCULAR

Murmur
Chest Pain
Palpitations
Fainting/Spells
Short of Breath
Difficulty Lying Flat
Swelling in Ankles
Pacemaker/Defibrillator

ENDOCRINE

Loss of Hair
Heat Intolerance
Cold Intolerance
Diabetes Type I or II

ALLERGIC

Hives/Eczema
Hay Fever

PSYCHIATRIC

Anxiety
Depression
Mood Swings
Difficulty Sleeping

RESPIRATORY

Cough
Coughing Blood
Wheezing
Chills
GASTROINTEST
Heartburn/Reflux
Nausea/Vomiting
Constipation
Change Bowel Mvts
Diarrhea
Jaundice
Abdominal Pain
Black/Bloody Bowel Mvts

GENITOURINARY

Burning/Frequency
Nighttime
Blood in Urine
Erectile Dysfunction
Bladder Leakage
Abnormal Leakage

HEMATOLOGY/LYMPH

Bruise Easily
Gums Bleed Easily
Enlarged Glands

MUSCLE/BONE

Joint Pain/Swelling
Stiffness
Muscle Pain
Bone Pain

SKIN

Rashes/Sores
Lesions
Itching/Burning

NEUROLOGICAL

Loss of Strength
Numbness
Headaches
Tremors
Memory Loss

CANCER

Date of diagnosis: _____
Location: _____
Status: _____

FEMALES ONLY

Age Onset of Periods _____
Periods Regular? Yes/No _____
Age Onset of Menopause _____
Number of Pregnancies _____

Please list any allergies that you have (For example: medications, latex, food, bee stings): _____

Is there any additional information? _____

The above information is true to the best of my knowledge.

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Designate Individuals Authorization Form

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Please give the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Acknowledgement of Office Policies

The following are Merrimack Valley Physical Therapy policies governing appointment scheduling, payment terms, and information releases. Please read carefully and be sure to ask questions you might have before signing the document.

Appointment Scheduling: We at Merrimack Valley Physical Therapy are glad to accept insurance assignment on your behalf in handling your personal injury or worker's compensation claim. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. We require a 24 hour cancellation notice for all appointments. If you miss three (3) or more appointments without 24 hour notice, you may be dismissed from care and your file may be closed.

Consent for Treatment: I, the undersigned, give Merrimack Valley Physical Therapy my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, condition may worsen on rare occasions. I further understand that no guarantee or promise has been made to me concerning the results of treatment. I further understand that the gym and/or pool areas are common areas accessed by patients, gym members and guests and as a result there may be incidental contact with personal health information.

Assignment of Payment: I hereby authorize my insurance company and/or my attorney to pay direct to Merrimack Valley Physical Therapy any monies due on my account for professional services rendered.

Acknowledgment and Understanding: It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Private Health Insurance: I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments).

Authorization to Release Information: I have read and fully understand Merrimack Valley Physical Therapy's Notice of Information Practices. I understand that Merrimack Valley Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments, understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Merrimack Valley Physical Therapy will consider requests for restriction on a case by case basis , but does not have to agree to requests for restrictions.

Patient Requests for Records: I instruct the release of all medical, hospital, or surgical records pertinent to my case, including but not limited to exams, special test, x-rays, or lab results to this office.

Ownership: I understand that Merrimack Valley Physical Therapy are all owned and operated by the same entity. I understand I have the option to seek any/all of the same services these clinics provide elsewhere.

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature: _____ Date: _____
Name (Please Print): _____ DOB: _____
Witness Signature: _____ Date: _____
Name (Please Print): _____

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Acknowledgement of Privacy Policy (HIPAA)

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Merrimack Valley Physical Therapy's *Notice of Privacy Practices for Protected Health Information*.

Patient Name Printed: _____ Date: _____

Patient Signature or Authorized Representative: _____ Date of Birth: _____

Authorized Representative Name Printed and Relation to Patient: _____