MEDICAL HISTORY/ INTAKE FORM

PATIENT NAME			DATE OF BIRTH		AGE
REASON FOR THERAPY			DATE OF INJURY / ONSET		GENDER
ADDRESS		CITY		STATE	ZIP CODE
CELL PHONE#	HOME PHONE #		WORK PHONE#		
EMERGENCY CONTACT / PHONE #					

Is the reason for therapy accident related? YES □NO □ If yes, please check one: □Automobile □Accident □ Work □ Other If other, please explain:

Are you currently receiving any other care for the condition mentioned above? YES □ NO □ If yes, please list:

Have you ever received therapy in the past for the condition mentioned above? YES □ NO □ If so, when?

Previous treatment received: Successful: YES □ NO □

Have you ever received therapy services for other problems /conditions during this calendar year? YES □ NO □

Could you be or are you pregnant? YES □ NO □

Do you now have or have you ever had any of the following conditions?

ARTHRITIS	YES	NO	DIABETIES	YES	NO	NUMBNESS / TINGLING	YES	NO
OSTEOPOROSIS	YES	NO	ANEMIA	YES	NO	THYROID PROBLEMS	YES	NO
HIGH BLOOD PRESSURE	YES	NO	SWELLING IN ANKLES	YES	NO	HEADACHES	YES	NO
HEART DISEASE / HEART ATTACK	YES	NO	DEEP VEIN THROMBOSIS (DVT)	YES	NO	HEAD INJURY / CONCUSSION	YES	NO
PACEMAKER	YES	NO	SEIZURES / EPILEPSY	YES	NO	HERNIA	YES	NO
STROKE	YES	NO	FATIGUE / WEAKNESS	YES	NO	KIDNEY/ BLADDER PROBLEMS	YES	NO
VASCULAR DISEASE	YES	NO	CANCER / TUMOR	YES	NO	PREVIOUS FRACTURES	YES	NO
HYPER SENSITIVE TO HOT / COLD	YES	NO	RECENT WEIGHT LOSS OR GAIN	YES	NO	PREVIOUS SURGERIES	YES	NO
ASTHMA	YES	NO	HIV / AIDS	YES	NO	METAL IN BODY / SURGICAL IMPLANTS	YES	NO
SHORTNESS OF BREATH	YES	NO	HEPATITIS	YES	NO	DEPRESSION	YES	NO
CHRONIC COUGH	YES	NO	TUBERCULOSIS	YES	NO	ANXIETY	YES	NO
DIZZINESS / FAINTING SPELLS	YES	NO	RECENT INFECTION	YES	NO	SMOKING	YES	NO
NAUSEA / VOMITTING	YES	NO	FEVER / CHILLS	YES	NO	OTHER (please describe below)	YES	NO

If you answered "yes" on any of the above or have other conditions not listed, please explain and give approximate date(s):

Are you presently taking any medications? □ **NO** □ **YES, list medications and specify condition:**

Do you have any allergies? □ **NO** □ **YES, List allergies:**

At the present time, would you say that your health is (circle one): Excellent Very Good Fair Poor

The information is correct to the best of my knowledge.

Patient / Parent / Guardian Signature **Date**

LAHAINA
PHYSICAL THERAPY

PAIN DIAGRAM AND PAIN RATING

Name: ____ **Date**: ________________________

INSTRUCTIONS: Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

Pins and Needles = 000000
Burning = xxxxxx
Stabbing = / / / / / /
Deep Ache = zzzzzz

Please rate your **current** level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your **worst** level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your **best** level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

LAHAINA PHYSICALTHERAPY

PATIENT AUTHORIZATION

Patient Name (print):	Date of Birth:

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at Lahaina Physical Therapy LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I consent to rehabilitation and related services at Lahaina Physical Therapy LLC. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Lahaina Physical Therapy LLC to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/ or payment for services provided.

I authorize Lahaina Physical Therapy LLC to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information. **Initial:** ________________

Assignment of Benefits

I authorize payment directly to Lahaina Physical Therapy LLC for services and to bill and release payment directly to Lahaina Physical Therapy LLC for any physical therapy, occupational therapy, speech-language pathology, and rehabilitation, orthotic or prosthetic services provided.

This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial: ________________

Notice of Privacy Practices (HIPAA Acknowledgement / Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Lahaina Physical Therapy LLC.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Initial ________________

Payment Guarantee

I agree to pay Lahaina Physical Therapy LLC for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

I accept responsibility for being aware of individual insurance plans, policies and benefits in regards to outpatient physical therapy. As a patient of Lahaina Physical Therapy LLC, I am responsible for the entire bill of services rendered should my insurance company deny payment for any reason. I understand that my good-faith payment may not be inclusive of all payments for which I am responsible and I may be billed for any remaining balance.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Lahaina Physical Therapy LLC.

Initial ________________

Patient Information & Data Sheet

I hereby acknowledge that the information I provided on the Intake Form and the Patient Data Sheet is correct.

Initial: ________________

Patient or Guardian Signature:	Date:

LAHAINA
PHYSICAL THERAPY

Thank you for choosing Lahaina Physical Therapy LLC for your physical therapy provider.

When attending physical therapy, please wear comfortable clothing for access to the injury and for ease and comfort when exercising. If a translator/interpreter is needed, please have them accompany you to all of your appointments. Please be courteous to the other scheduled patients, and arrive to your appointment on time. If you arrive late, please be prepared for either an extended waiting time or rescheduling of the appointment in order to assure quality care is provided to everyone.

We are sincerely dedicated in assisting you meeting your therapy goals. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to continually update your treatment program, which will result in quicker recovery and better outcomes.

We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, please give us as much notice as possible so we can reschedule your appointment and open that time slot for another client. If you are calling after hours you may leave a message at 661-5266. **Canceling an appointment with short notice or "no−showing" an appointment takes up clinic time that could benefit another person.**

In order to enforce this policy, you will be charged **$40** if you cancel an appointment less than 24 hours before your scheduled appointment time or do not show for an appointment. Your insurance does not cover charges for late cancellations or no−shows; it is the patient's responsibility. No showing or late cancellation for your scheduled appointments without 24 hours' notice more than three times will unfortunately limit your ability to schedule advanced appointments and will result in same day scheduling only. If you are receiving therapy under Workman's Compensation, recurrent cancellation and/or no shows will be documented and forwarded to your Case Manager and Primary Care Physician and may result in jeopardizing your Workman's Compensation benefits.

We want to make your physical therapy experience as beneficial as possible and your commitment is a very importance part of this. If you know you are going to have a difficult time making your appointments, please discuss options with your therapist and we will do our best to accommodate your needs. You may contact Lahaina Physical Therapy, at 808-661-5266.

To protect the privacy of our physical therapists and our patients and to avoid any HIPAA (Health Insurance Portability and Accountability Act of 1996) violations and applicable state privacy laws, please do not contact our physical therapists through their personal phone, email or any form of social media.

Mahalo

Patient/Parent/Guardian Signature: ______________________________ Date: ______________