Innovative Physical Therapy
828 Paoli Pike
West Chester, PA 19380
610-344-7210 (Phone) 610-344-7292 (Fax)
www.innovativephysicaltherapy.net

Patient Information

Thank you for choosing Innovative Physical Therapy! Please provide the following information so that we may serve you properly. All information provided will be kept strictly confidential.

Patient Name: _____ Date of Birth: _____ Age: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Cell Phone: _____ Home Phone: _____ Email Address: _____

Gender: Male ___ Female ___ Parent/Guardian's Name: (if under 18) _____

****

Employer: _____ Occupation: _____
Employer Address: _____ Phone: _____

Referring Physician: _____ Family Physician: _____
Address: _____ Address: _____
Phone: _____ Fax: _____ Phone: _____ Fax: _____

****

Please provide information below if applicable:
Medicare: ____ please provide your card and secondary if applicable to be copied

Workman's Comp: Insurance Carrier: _____ Contact Name: _____
Case # _____ Phone Number: _____

Motor Vehicle Insurance: Insurance Carrier: _____ Contact Name: _____
Case # _____ Phone Number: _____

Private Health Insurance: Insurance Carrier: _____
(please provide your card to be copied)

****

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

I understand that Innovative Physical Therapy expects prompt payment of all bills for services rendered. I realize that I am ultimately responsible for understanding and knowing my benefits which may be provided by my insurance carrier. I am responsible for prompt payment for all such charges.

Patient/Guardian Signature: _____ Date: _____

PATIENTS' RIGHTS AND RESPONSIBILITIES

Name _____

Address _____

I, _____, am a responsible consumer. I have the following rights:
The right for disclosure regarding costs The right for disclosure regarding benefits The right to make decisions regarding what happens to my or _____'s (client name, if other than self) BODY The right to question risk associated with any proposed treatment The right to request expected benefits of any proposed treatment The right to request a comparison of the benefits and risks possible both with and without any proposed treatment The right to request an explanation of reasonable alternatives to any proposed treatment. The right to access care by IPT. The right to patient care of the highest quality. The right for a plan of continuity of care. The right to be involved in the goals of treatment and plan of care

I, _____, am a responsible citizen. I agree to the following:
I will be responsible for financial reimbursement for all services rendered. I will recognize that I am responsible for disclosure of any and all information considered pertinent by management and clinical associates. I will practice acceptable behavior as accorded to me by management and clinical associates. I will inform management and clinical associates whenever I require any change in status regarding the above rights and privileges in a timely manner and in writing.

Signature of Client/Guardian _____ Date _____

NOTICE OF PRIVACY PRACTICES

Privacy Officer: Penny Zimmerman PT, ATC, IMTC
Acknowledgement of Receipt

Name of Patient: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

_____

For Office Use Only:
Signed form received by: _____
Acknowledgement refused:
Efforts to obtain: _____

Reasons for refusal: _____

CANCELLATIONS AND MISSED APPOINTMENTS

When you schedule an appointment, that time is reserved especially for you. When you miss an appointment, without calling to cancel within a reasonable period of time, your practitioner does not have the opportunity to offer that time to someone else in need of services. Missed appointments can also interfere with your progress in treatment.

It is our policy that patients are responsible for all appointments they have scheduled. Patients who choose not to attend or call to cancel their appointments are still responsible for these appointment times. Therefore, the following policy will apply:

- 24 HOURS (1 WORKING DAY) NOTICE IS REQUIRED TO CANCEL EACH ONE HOUR APPOINTMENT YOU HAVE SCHEDULED. (For example: 2 hours scheduled = 2 working days' notice; 3 hours scheduled, 3 working days' notice, etc.)

- FOR ANY LATE CANCELLATION OR MISSED APPOINTMENT, THE CHARGE WILL BE 100% OF THAT VISIT'S FEE.

Fees for missed appointments and/or late cancellations are expected at or before the patient's next scheduled appointment. Insurance does not cover these fees.

Any patient who misses more than two appointments without sufficient notice of cancellation during his or her course of treatment is subject to review and may be required to prepay for scheduled sessions.

Clients can call to check if the therapist is running on time. If the therapist is late, the patient will not lose any treatment time. When the client is late for the session, the client incurs the loss of time, and payment for the full session is expected. Any exceptional circumstances will be submitted to our Practice Manager for review.

Patient or Guardian Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF RECORDS

Patient Name _____

PLEASE LIST ANY INSURANCE COMPANIES AND/OR HEALTH CARE PROVIDERS THAT YOU WOULD LIKE TO AUTHORIZE RELEASE OF YOUR MEDICAL RECORDS TO UPON THEIR REQUEST.

RECORDS RELEASE TO INSURANCE I authorize Innovative Physical Therapy to release pertinent clinical and account information to the following insurance companies to facilitate my reimbursement:

1. _____
2. _____
3. _____

RECORDS RELEASE TO HEALTHCARE PROVIDERS I authorize Innovative Physical Therapy to release pertinent clinical and account information to the following practitioners:

1. _____
2. _____
3. _____

Patient or Guardian Signature _____ Date _____

Innovative Physical Therapy
828 Paoli Pike
West Chester, PA 19380
610-344-7210 (Phone) 610-344-7292 (Fax)
www.innovativephysicaltherapy.net

INTAKE INFORMATION

Date	Patient Name	Current Age

Please complete the following information in detail. This will assist us in designing the most effective and efficient individualized program for you. Every item is significant and important. Thank you for your effort. Please print neatly.

Who recommended you to this office? _____

Official Diagnosis or Main Problem: _____

_____

Reason for visit (if different from above) _____

_____

IMPORTANT: To the patient: Please list below the main complaints/challenges you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Please report all current areas of pain and the usual range of pain (0 no pain, 10 excruciating/debilitating pain).

RANGES of PAIN: (For Example √ Head 4-7)

☐Head
☐Face
☐Jaw
☐Front of Neck
☐Back of Neck
☐Right Side of Neck
☐Left Side of Neck
☐Right Shoulder
☐Left Shoulder
☐Right Upper Arm
☐Left Upper Arm
☐Right Elbow
☐Left Elbow
☐Right Lower Arm
☐Left Lower Arm
☐Right Wrist
☐Left Wrist
☐Right Fingers
☐Left Fingers
☐Upper Back
☐Chest/Rib Cage
☐Abdomen
☐Lower Back
☐Buttocks
☐Right Hip
☐Left Hip
☐Right Front Thigh
☐Left Front Thigh
☐Right Back Thigh
☐Left Back Thigh
☐Right Knee
☐Left Knee
☐Right Shin
☐Left Shin
☐Right Foot
☐Left Foot
☐_____
☐_____
☐_____

Please indicate what makes your pain worse:

___Lying Down
___Sitting
___Standing
___Walking
___Driving
___Running
___Working
___Time of Day
___Too Much Activity
___Bending
___Reaching
___Lifting
___Squatting
___Kneeling
___Too Little Activity
___Other (Specify): _____
_____
_____

What makes your pain decrease? (Explain):

___Lying Down
___Sitting
___Standing
___Walking
___Driving
___Running
___Working
___Time of Day
___Too Much Activity
___Bending
___Reaching
___Lifting
___Squatting
___Kneeling
___Too Little Activity
___Other (Specify): _____
_____
_____

When did your pain begin? (Weeks, Months, Years ago)? _____
At Birth? _____ Date: _____

Was your onset of pain sudden? _____ Gradual? _____ Explain (if necessary):

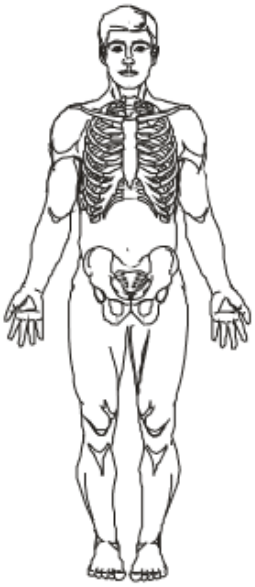
_____

_____

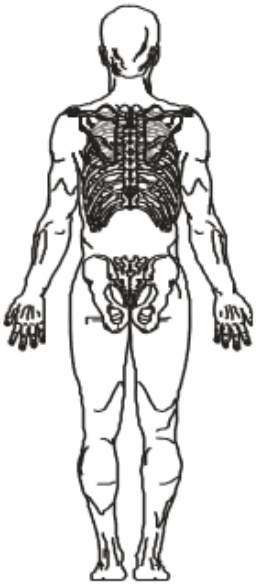
_____

Pain Diagram: Please shade in all areas of pain. Be as thorough and specific as possible.

Front:



Back:

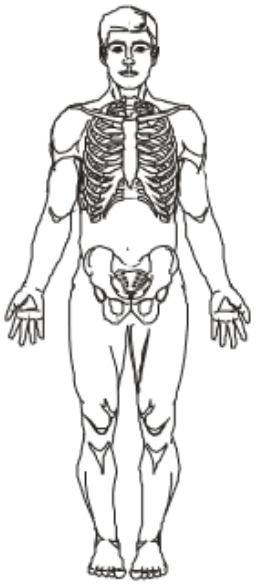


Right Side:

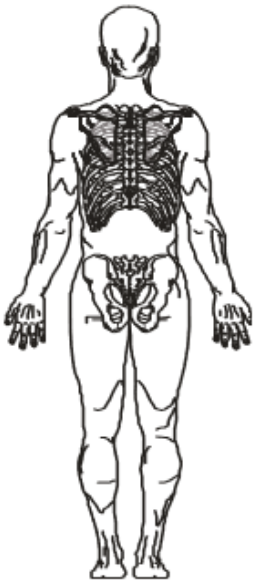
Left Side:

Paresthesia Diagram: Please shade in all areas of "funny feeling" (tingling, burning, pins and needles, etc.)

Front:



Back:



Right Side:

Left Side:

Please tell us about your symptoms by checking the appropriate areas:

	Frequency			Severity		
	Occasional	Often	Constant	Mild	Moderate	Severe
Dizziness, light-headed						
Pass out easily (faint)						
Decreased concentration/attention						
Short term memory loss						
Slurred speech						
Balance or coordination problems						
Headaches						
Nausea						
Indigestion						
Difficulty swallowing						
Ears: ringing, stuffy, painful						
Vision: blurring, burning, aching, pressure, change, double						
Drooping eyelid or any changes in your pupils						
Allergies						
Sinus problems						
Nagging cough, hoarseness						
Chest pain						
Cold hands						
Cold feet						
Stiffness						
Bowel problems						
Unusual bleeding or discharge						
Sexual function problems						
Change in any wart or mole						
Sore that does not heal						
Thickening in your breast/elsewhere						
Snore						
Pain wakes you up from a sound sleep						
Night sweats						

Function: Activities of daily living are compromised as follows:

Bed Activities:	☐Lying on stomach is	☐Painful	☐Difficult	☐Not Possible
	☐Lying on back is	☐Painful	☐Difficult	☐Not Possible
	☐Lying on right side is	☐Painful	☐Difficult	☐Not Possible
	☐Lying on left side is	☐Painful	☐Difficult	☐Not Possible
	☐Rolling over in bed is	☐Painful	☐Difficult	☐Not Possible

Transfer Activities: ☐Lying to sit is ☐Painful ☐Difficult ☐Not Possible
☐Sit to lying is ☐Painful ☐Difficult ☐Not Possible
☐Sit to stand is ☐Painful ☐Difficult ☐Not Possible
☐Stand to sit is ☐Painful ☐Difficult ☐Not Possible

Standing is: ☐Painful ☐Difficult ☐Not Possible
Present standing tolerance: _____ min/hours

Sitting is: ☐Painful ☐Difficult ☐Not Possible
Present sitting tolerance: _____ min/hours

Driving is: ☐Painful ☐Difficult ☐Not Possible
Present driving tolerance: _____ min/hours

Sitting in a car is: ☐Painful ☐Difficult ☐Not Possible
Present sitting tolerance in car: _____ min/hours

Walking is: ☐Painful ☐Difficult ☐Not Possible
Present walking tolerance: _____ min/hours

Running is: ☐Painful ☐Difficult ☐Not Possible
Present running tolerance: _____ min/hours

Work is: ☐Painful ☐Difficult ☐Not Possible ☐Compromised
Present work tolerance: _____ min/hours

Upstairs are: ☐Painful ☐Difficult ☐Not Possible

Downstairs are: ☐Painful ☐Difficult ☐Not Possible

Bending and lifting activities are: ☐Painful ☐Difficult ☐Not Possible

Reaching activities (with arms) are: ☐Painful ☐Difficult ☐Not Possible

Sport and leisure activities are: ☐Compromised ☐Not Possible

☐**All activities/ADLs are performed despite** ☐pain ☐fatigue ☐lack of energy ☐headaches

Other: _____ ☐Painful ☐Difficult ☐Not Possible

How many hours do you sleep at night? _____

How many hours per day (in 24 hours) do you spend in bed? _____

How would you consider your present level of activity? ☐Poor ☐Fair ☐Good

Please list your present hobbies: _____
_____

Work/Occupation: Please state what you do for a living: _____

Please indicate the hours you spend at work per week: _____

If you are currently not working, how long have you not worked? _____

Are you not working for reasons other than your pain/problem? ☐ Yes ☐No
If so, what reason? _____

Are you a full-time homemaker? ☐ Yes ☐No

	Before pain/disability	After pain/disability
Hours per week spent working at a paying job?		
Hours per week spent doing household chores?		
Hours per week spent doing a volunteer job?		

Are you presently receiving compensation (disability insurance)? Yes No

If not, are you considering or have you applied for compensation of any kind? _____

If you anticipate returning to work, when do you hope to do so? _____

Please describe how your present living situation is different from the way it was before you experienced pain/disability problems: _____
_____

Current Assistive Devices:

Cane	☐Yes	☐No	Dentures	☐Yes	☐No
Walker	☐Yes	☐No	Prosthetics	☐Yes	☐No
Manual Wheelchair	☐Yes	☐No	Shunts	☐Yes	☐No
Motorized Wheelchair	☐Yes	☐No	Pacemaker	☐Yes	☐No
Corrective Lenses/Glasses	☐Yes	☐No	Insulin Pump	☐Yes	☐No
Hearing Aids	☐Yes	☐No	Baclofen Pump	☐Yes	☐No

Other: _____

Present Home Environment:

Stairs, no railing	☐Yes	☐No	Uneven Terrain	☐Yes	☐No
Stairs, railing	☐Yes	☐No	Bathroom modifications	☐Yes	☐No
Ramps	☐Yes	☐No	Any other obstacles:	☐Yes	☐No
Elevator	☐Yes	☐No	Explain: _____		

Current and Past Medical History:

☐Alcoholism
☐Allergies
☐Alzheimer's Disease
☐Anxiety
☐Arthritis
☐Asthma
☐Attention Deficit Disorder (ADD)
☐Attention Deficit Hyperactivity Disorder
☐Autoimmune Disease
☐Back Pain
☐Bronchitis
☐Cancer/What Type

☐Carpal Tunnel Syndrome
☐Cerebral Palsy
☐Cholesterol, Elevated
☐Chronic Fatigue Syndrome
☐Circulatory Problems
☐Colitis
☐Concussions
☐Dental Problems
☐Depression
☐Diabetes
☐Diverticular Disease
☐Drug Addiction
☐Eating Disorder
☐Epilepsy
☐Environmental Sensitivities
☐Eyes, Ears, Nose, Throat Problems
☐Facial Palsy
☐Fibromyalgia
☐Food Intolerance
☐Gastrointestinal
☐Genetic Disorder
☐Glaucoma
☐Gout
☐Headaches/Frequency: _____ Duration: _____ Intensity/Range 0-10: _____
☐Heart Disease
☐High Blood Pressure
☐Infection, Chronic (Type)
☐Inflammatory Bowel Disease
☐Irritable Bowel Syndrome
☐Kidney or Bladder Disease
☐Learning Disabilities
☐Liver or Gallbladder Disease (Stones)
☐Lyme's Disease
☐Lymphedema
☐Lymphatic Problems
☐Mental Illness
☐Mental Retardation
☐Migraine Headaches/Frequency: _____ Duration: _____ Intensity/Range 0-10: _____
☐Mononucleosis
☐Multiple Sclerosis
☐Musculoskeletal Problems
☐Obesity
☐Osteoporosis
☐Paraplegia
☐Parkinson's Disease
☐Phobias
☐Pneumonia
☐Quadriplegia
☐Respiratory Problems
☐Rheumatoid Arthritis
☐Seasonal Affective Disorder
☐Sexually Transmitted Disease
☐Sinus Problems
☐Skin Problems
☐Spina Bifida
☐Stroke
☐Thyroid Trouble
☐Traumatic Brain Injury (TBI)
☐Tuberculosis
☐Ulcer
☐Urinary Tract Infection
☐Varicose Veins
☐Other _____

Medical (Men):

☐Benign Prostatic Hypertrophy
☐Decreased Sex Drive
☐Infertility
☐Prostate Cancer
☐Sexually Transmitted Disease
☐Other _____

Medical (Women):

☐Breast Cancer
☐Breast Surgery/Reduction/Implants
☐Decreased Sex Drive
☐Endometriosis
☐Fibrocystic Breasts
☐Fibroids/Ovarian Cysts

☐Infertility
☐Hysterectomy _____Partial _____Full
☐Menstrual irregularities
☐What was the date of onset of last menses?
☐Pelvic Inflammatory Disease
☐Other _____

☐PMS
☐Sexually Transmitted Disease:
☐Vaginal Infections
☐Incontinence
☐Bladder Infections

List all trauma and when it occurred (All trauma, accidents injuries are important, not just recent ones.):

_____
_____
_____

List any operations you have undergone and dates (approximately):

_____
_____
_____

List any hospitalizations and dates (approximately):

_____
_____
_____

What was your last vaccination/inoculation? _____
Did you become ill? ☐Yes ☐No

When have you traveled out of the country? _____
Did this require inoculation? ☐Yes ☐No
Did you become ill? ☐Yes ☐No

Are you losing weight without trying? ☐Yes ☐No
Are you coughing up blood or noticing it in your stool or urine? ☐Yes ☐No
Have you lost consciousness or had double vision recently? ☐Yes ☐No

Family Health History:

☐Alcoholism _____
☐Alzheimer's Disease _____
☐Arthritis _____
☐Asthma _____
☐Cancer _____
☐Depression _____
☐Diabetes _____
☐Drug Addiction _____
☐Eating Disorder _____
☐Genetic Disorder _____
☐Glaucoma _____
☐Heart Disease _____
☐High Blood Pressure _____
☐Infertility _____

☐Learning Disabilities_____
☐Mental Illness_____
☐Migraine Headaches_____
☐Neurological Disorders (Parkinson's, Paralysis)_____
☐Obesity_____
☐Osteoporosis_____
☐Rheumatoid Arthritis_____
☐Stroke_____
☐Other_____

Health Habits:

☐Tobacco: Cigarettes #/day _____ Cigars #/day _____ Pipe _____ Chewing _____
☐Alcohol: Wine or beer #glasses/day or week _____ Liquor # ounces/day or week _____
☐Caffeine: Coffee: #6 oz cups/day _____ Tea: #6 oz cups/day _____
☐Soda w/caffeine: # cans/day _____ Diet Sodas #cans/day _____
☐Other: _____

Exercise: (Check all that apply)

☐5-7 days per week
☐3-4 days per week
☐1-2 days per week
☐Infrequent
☐Never
☐45 minutes or more duration per workout
☐30-45 minutes duration per workout
☐Less than 30 minutes

☐Walk
☐Swim
☐Run, Jog, Jump Rope
☐Weightlifting
☐Yoga
☐CrossFit
☐Exercise Class
☐Organized Sports/Other: _____

Nutrition and Diet:

☐Vegetarian
☐Vegan
☐High Protein
☐Salt Restriction
☐Low Fat Diet
☐Other: _____
☐Other: _____

☐Starch/Carbohydrate Restriction
☐The Zone Diet
☐Atkins Diet

Specific Allergies or Food Restrictions:

☐Dairy ☐Eggs ☐Soy ☐Corn ☐All Gluten ☐Wheat ☐Sugar
☐Peanuts ☐Latex ☐Other: _____

Circle the level of stress you are experiencing on a scale of 1-10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems):

_____

_____

_____

List any prescribed, over the counter medications and/or supplements you are taking.

Name of those presently taking	Dosage	For how long?	List any Medications/Supplements you have taken over the past 5 years:

☐Attach a piece of paper if needed.

Are you seeing any doctors or health care professionals now for any reason? (Note: These practitioners will not be contacted without your permission. Do you want us to send our evaluation note to these practitioners? ☐Yes ☐No

Practitioner's Name	**Type of Practitioner:**	**Phone Number or Address:**

While you are a patient here at Innovative Physical Therapy, a goal list will help us recognize what you would like to accomplish. Your therapist will evaluate you with your input in mind. "Patient Centered Goals" will serve as the basis for treatment. Goals will be revised as needed.

Please fill in the following so the therapist can consider your desires/goals.
The following examples are provided to assist you to answer.
I know I will be better when I can:
Example 1. Walk independently for 15 minutes with no pain.
Example 2. Work using just a splint for a half day with occasional pain.
Example 3. Sit with the help of only one person for 30 seconds.
Example 4. Play 18 holes of golf without pain in my back.

Please fill in the chart below, answering "I know I will be better when I can:

1. _____
2. _____
3. _____
4. _____
5. _____