Oregon Physical Therapy at Timberhill

Health Intake Form

Name: ______________________________ **Date:** ____________________

Weight: ____________________ **Height:** ______________

On the scale below, please mark the number which best represents the severity of your pain over the past 24 hours:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Imaginable

Since your symptoms began, have you noticed any of the following? (Check all that apply)

- ☐ Fatigue
- ☐ Generalized muscle weakness
- ☐ Pain at night
- ☐ Leg swelling
- ☐ Weight Loss/Gain
- ☐ Difficulty maintaining balance when walking
- ☐ Changes in bowel or bladder function
- ☐ Changes in cognition
- ☐ Falls in the last year #___
- ☐ Numbness or tingling
- ☐ Shortness of breath
- ☐ Heartburn/Indigestion
- ☐ Difficulty swallowing
- ☐ Headaches
- ☐ Changes in appetite
- ☐ Heart palpitations
- ☐ Fever/Chills/Sweats
- ☐ Nausea/Vomiting
- ☐ Abdominal pain
- ☐ Dizziness/ Imbalance
- ☐ Cough
- ☐ Chest pain especially with sweats
- ☐ Skin changes
- ☐ Other: ______________________

Medical History: Have you ever been diagnosed with or do you have any of the following conditions? (Check all that apply)

- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/ Angina
- ☐ Circulation Problems
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Chemical dependency: i.e. (Alcoholism)
- ☐ Depression
- ☐ Anxiety
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Sexually transmitted disease/HIV
- ☐ Rheumatoid arthritis
- ☐ Arthritis
- ☐ Bladder/Urinary tract infection
- ☐ Kidney problems/Infection
- ☐ Cholesterol High/Low
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Ulcers
- ☐ Liver problems
- ☐ Allergies/Asthma
- ☐ Pacemaker
- ☐ Blood thinners
- ☐ Fibromyalgia
- ☐ Broken bones
- ☐ Hepatitis
- ☐ Recent infection/Illness(Explain)
- ☐ Hypertension: High/ Low Blood Pressure

Past surgical history (List and Date):

____

____

Current Symptoms:

Problem(s) you are here for: ______________________________

What date (roughly) did your symptoms start? ______________________________

What do you think started your symptoms? ______________________________

Are your symptoms related to a work injury? ☐ Yes ☐ No Or a motor vehicular accident? ☐ Yes ☐ No

Symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same

☐ Come and go ☐ Constant ☐ Constant, but change with activity

Treatments so far for this problem (Injections, Chiropractic, etc.): ______________________________

Have you had X-ray, MRI, or other imaging done for this problem? ☐ Yes ☐ No

If yes, please list, including the date: ______________________________

Have you ever had this problem before? ☐ Yes ☐ No

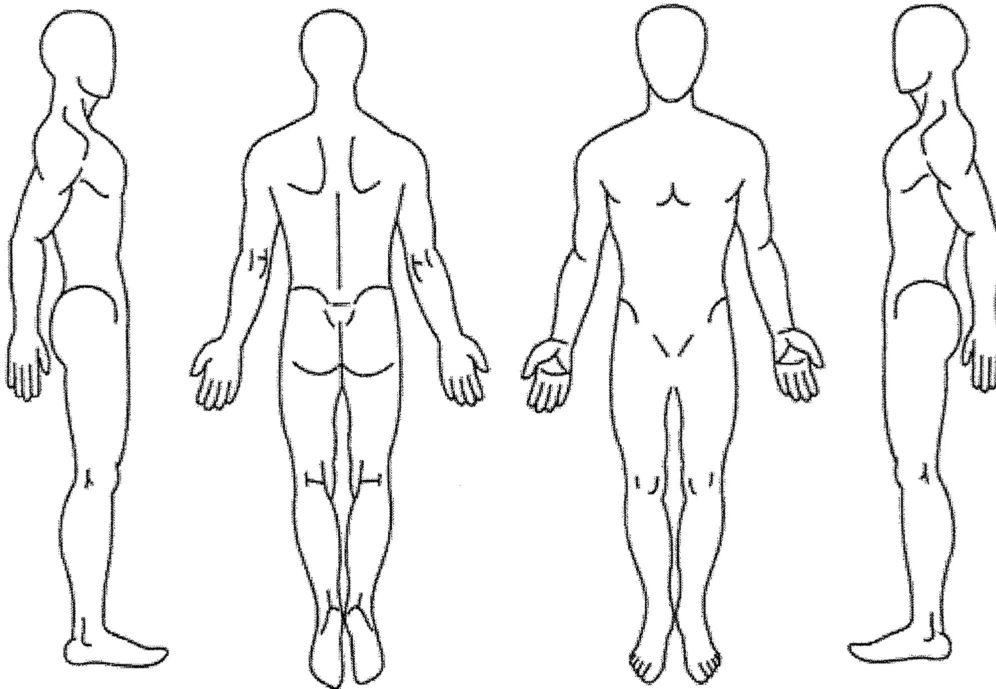
If yes, when and how was it treated?

____

What is your personal goal for therapy? ______________________________

Body Chart:

***Please mark **ALL** areas where you feel symptoms on the chart*



What makes your symptoms better? ______________________________

What makes your symptoms worse? ______________________________

Are you able to sleep at night?

☐ Fine ☐ Moderate difficultly

☐ Only with medication

Medication List/ See Attached: ______________________________

____

____

Medication List

Name:_________________________________

Medication	Dosage	Frequency	Method of Administration
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:

Patient Signature: ______________________________ Date: ______________

Reviewed by: ________________________________ Date: ______________

Oregon Physical Therapy at Timberhill

Patient Intake Form

Date: ______________________

Name: ____________________________ Address: ____

City: __________________________State: ___________________Zip Code: ___________________

Home Phone: (____)_________________________Cell Phone: (____)__________________________

Would you like a text message reminder? ☐ Yes ☐ No Cell Phone Carrier: _______________________

Email: ____

DOB: _____/_____/___________ Gender: ☐ M ☐ F ☐ Non-Binary Marital Status: S / M / D / W

Occupation: ____________________________Employer: ____________________________________

Work Phone: (____)_______________ Emergency Contact: ____________________________________

Relation to emergency contact:______________________ Phone #: (____)_______________________

Primary Care Physician: ________________________Referring Physician: _______________________

Is this a ☐ Motor vehicle accident ☐ Workers Comp? If so, what was the date of injury? ___/___/_____

How did you hear about our clinic?

☐ My doctor's office ☐ I am a former patient ☐ Family/ Friend/ Colleague recommended ☐ My insurance company said you were in my network ☐ I did a search on the internet ☐ My trainer

☐ Other: _________________

Please tell us who we can thank for sending you our way:

____

*****PLEASE PRESENT YOUR INSURANCE CARD(S) AND PHOTO ID AT THE FRONT DESK*****

PATIENTS SIGNATURE: ______________________________________ DATE: ______________________

Oregon Physical Therapy at Timberhill

Consent of Treatment

I hereby consent to evaluation and, or treatment of my condition by a licensed physical therapist employed by or under contract with Oregon Physical Therapy at Timberhill, LLC. I am aware that the physical therapist will inform me of the expected benefits and possible discomfort, which may result from skilled physical therapy care.

I am aware that there is no guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition. I confirm that I have read and fully understand this consent form.

In regards to communication with my therapist, I am aware that e-mail is not a secure method of communication. By initiating or responding to an e-mail, I am giving my consent to communicate in this manner and understand that there are risks to my protected health information.

Release of Information

I Authorize the release of any medical information or other information necessary to process insurance claims by the health practice, Oregon Physical Therapy at Timberhill, LLC.

I understand and agree that Oregon Physical Therapy at Timberhill, LLC may release my medical records and discuss health related, and financially related information or issues to health care providers, insurance representatives, case managers, and lawyers that are involved in my case.

I agree with the HIPAA notice of privacy practices for physical therapy form, freely located at the front desk, and understand I can receive a personal copy upon request at any time.

Assignment of Benefits and Payments

I authorize Oregon Physical Therapy at Timberhill, LLC, to contact and submit billings/ claims to my insurance provider on my behalf, and have these payments be made, and sent to Oregon Physical Therapy at Timberhill, LLC directly. I consent to pay all current and outstanding balances on my account within 30 days of receiving a balance due statement. This includes all co-pays, co-insurances, deductibles, and non-covered charges.

I understand that it my responsibility to personally contact my insurance company to received benefits in accordance of care for physical therapy under my specific plan.

CO-PAYS are due at the time of service. If you must cancel your appointment, do so 24 hours in advance. Should you cancel on the same day or not attend a scheduled appointment there will be a $25.00 charged fee for the missed visit.

PATIENT'S PRINTED NAME: ______________________________

PATIENT SIGNATURE: _________________________________ DATE: ____________