Name:_____

PATIENT INFORMATION:

Date of Birth: _____ SSN#: _____

Circle: Married/Single/Other Circle: Male/ Female

Primary Phone: _____Cell or Home? (Circle one), Can we leave a message? Y or N

Secondary Phone: _____ Cell or Home? (Circle one), Can we leave a message? Y or N

Email (for occasional Clinic updates) :_____

Appointment reminders (circle one): Text Email None

Address:

_____

Street City State Zip Code

Emergency Contact: _____ Phone Number: _____

Relationship: _____

WHAT BRINGS YOU HERE?

Who is your referring physician? _____

Phone number _____ Clinic _____

Are you under the care of another physician? If so, please list:_____

How did you hear about us? _____

Is this related to an auto accident? Yes/ No Is this related to workers compensation injury? Yes/ No

If this is Worker's Compensation or Auto Accident, what was the date of your Injury: _____

Adjuster's Name: _____ Phone Number: _____

INSURANCE INFORMATION: (see financial policy for detailed information)

Primary Insurance: _____

Secondary Insurance: _____

Name:_____

Other Information

Patient Authorization

All information provided for start of care is true and correct to the best of my knowledge. I am aware of my diagnosis and wish to receive treatment and/or wellness care from Ascend Physical Therapy, PC. I permit the therapist to provide treatment in ways she/he judges is best and most beneficial for me. I understand, and am aware treatment may involve bodily contact, touching, and/or direct contact of a sensitive nature. I understand this contact may be part of the examination and/or treatment. No guarantees have been provided to me regarding the outcome of care provided.

I give permission to Ascend Physical Therapy, PC to release information, verbal or written, from my medical record or related information, to my insurance company, rehab nurse, case manager, attorney, employer, law enforcement, school, referring/related health care provider, and/or any other person related to treatment/payment for services provided.

I authorize my therapist to obtain further medical/pertinent information from my physician and others providing health and wellness treatment/care. I understand it is my responsibility to inform the therapist of all forms of treatment I am undergoing while utilizing the services of Ascend Physical Therapy, PC.

Initials _____

Cancellation Policy: We understand that emergencies happen and your schedule may change, but please give us minimum 24 hours ahead of your appointment time. In order for us to provide high quality care and offer longer one-on-one sessions, we need a 24 hour opportunity to fill any new openings in the schedule. We appreciate your cooperation and understanding with this. Cancellations under 24 hours will result in penalty fees. The first occurrence is $20, and subsequent cancellations are $40.

Initials_____

HIPAA Acknowledgment/ Privacy Practices Notice: I hereby acknowledge I have received a copy of Ascend Physical Therapy, PC practices. I consent to the use and disclosure of my health information for the purposes of treatment, payment and health care operations.

Initials_____

Records Request (if necessary):

I authorize_____ access to my medical records/data.

Initials_____

HIPAA allows 30 days for medical record requests . Fee for copies will be $14.00 for the first ten or fewer pages, $0.50 per page for pages 11-40, and $.33 per page for every additional page. You must also sign authorization for medical record release for official copies to be sent to third parties.

Initials_____

Name:_____

Patient History Form

To give you the highest quality care, it is best to have a good understanding of any past medical events or current, complicating diagnoses.

Condition	Yes	No	Condition	Yes	No
Allergies			Falls		
Alcohol or Substance Abuse			Fractures		
Arthritis			Headaches		
Blood Clots			High Blood Pressure		
Blurred Vision			HIV/AIDS		
Bowel or Bladder Issues			Low Blood Pressure		
Cancer			Pacemaker		
Confusion			Poor Balance		
Diabetes (Type 1 or Type 2?)			Shortness of breath or asthma		
Dizziness			Surgeries		
Epilepsy/Seizures			Stroke		

Please provide more information for anything answered “yes” above or any other medical conditions:

Please list all medications:

Previous injuries/surgeries/accidents?

4935 N 30th St, Suite 100, Colorado Springs CO 80919
Phone (719) 266-1710 ● Fax (719) 623-0041 ● www.ascend-physicaltherapy.com info@ascend-physicaltherapy.com

Name:_____

Current Symptoms

Briefly describe your symptoms:

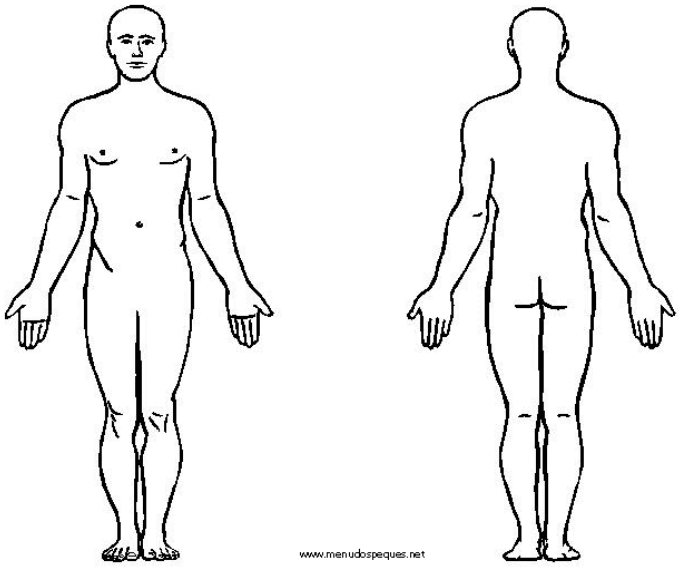
When did your symptoms start?

Please rate your pain, with '0' being no pain, and '10' being severe pain that would prompt you to go to the hospital, and mark the location of your symptoms on the image:

At worst: 0 1 2 3 4 5 6 7 8 9 10

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

At best: 0 1 2 3 4 5 6 7 8 9 10



What makes your symptoms worse?

What makes your symptoms better?

What are your goals? What do you hope to accomplish with physical therapy?

I verify that the information provided on this intake is accurate to the best of my knowledge

Signature_____ Date_____

4935 N 30th St, Suite 100, Colorado Springs CO 80919
Phone (719) 266-1710 ● Fax (719) 623-0041 ● www.ascend-physicaltherapy.com info@ascend-physicaltherapy.com