Peak Motion
Physical Therapy

Initial Evaluation Intake Forms

Name:_____**Date of Birth:**____/____/_____

Phone: _____ **Email:** _____

Address:_____ _____ _____
Street City, State Zip

Emergency Contact/Relationship:_____ **Phone:**_____

Referring Physician:_____**Primary Physician:**_____

Who can we thank for your referral?_____

GENERAL HEALTH STATUS
Please rate your health: Good____ Fair____ Poor____

MEDICAL HISTORY (Have you had or do you currently have any of the following?)

___Alzheimer's
___Cardiovascular Disease
___Pacemaker
___Heart Attack
___Heart Surgery
___Blood Clot
___Cauda Equina Syndrome
___CVA (stroke)/TIA
___Current Infection
___Diabetes Mellitus Type 1
___Diabetes Mellitus Type 2
___Fibromyalgia
___Fracture Or Suspected Fracture
___High Blood Pressure
___History Of Cancer
___Chemo
___Radiation
___Lymph nodes removed
___Huntington's
___Immunosuppression
___Lupus
___Muscular Dystrophy
___Obesity
___Osteoarthritis
___Parkinson's
___Rheumatoid Arthritis
___Traumatic Brain Injury

Have you ever had surgery? Yes____ No____
If yes, please describe and include dates:_____

___Allergies
___ Latex
___Bowel/Bladder Problems
___Dizziness or Fainting (circle)
___Epilepsy/Seizures
___Infectious Disease
___Sleeping Difficulties
___Thyroid Problems
___Joint Replacement
___Multiple Sclerosis
___Night Pain
___Numbness or Tingling
___Osteoporosis
___Pins or Metal Implants
___Vision or Hearing Difficulty (circle)
___Severe Frequent Headaches
___Shortness of Breath/Chest Pain
___Asthma
___Bronchitis
___Emphysema
___Weakness
___Weight Loss/Energy Loss

Other_____

Imaging Studies? _____ Results?_____

MEDICATIONS:
Please list prescription, over the counter, vitamins, supplements, minerals, etc.

_____

_____

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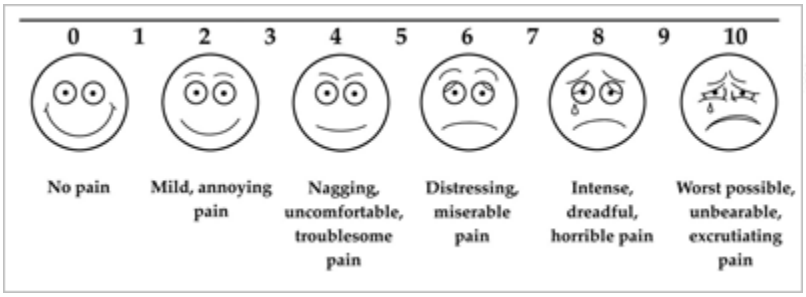
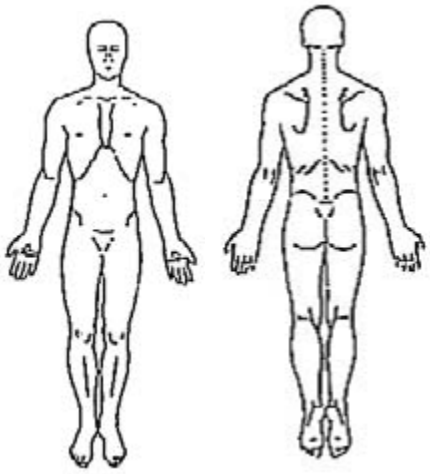
CURRENT CONDITION(S) / CHIEF COMPLAINT(S)
Describe the problem(s) for which you seek physical therapy:_____
_____

What are your goals for physical therapy? _____
_____

PAIN (Please rate your pain over the past 24 hours on a scale of 1-10. Mark pain on body chart.)
Current Pain _____ Pain at Best _____ Pain at Worst _____





Please describe your pain:

___constant	___dull	___pins/needles
___intermittent	___aching	___numbness
___sharp	___stabbing	___wakes you at night

Are you ever pain free? Yes___ No___ Was the onset gradual? Yes___ No___
When did these problems begin? _____
If there was an injury, describe injury:_____
_____

How is your current condition progressing? Improving___ Staying the same___ Getting worse___

What decreases your pain? Heat___ Ice___ Rest___ Medication___ Other_____

What increases your pain? Sitting___ Walking___ Bending___ Squatting___ Stairs___ Push/Pull___
Standing___ Kneeling___ Reaching___ Lifting___ Rising from chair___ Other_____

Are you able to continue your usual recreational activities? Yes___ No/Limitied___ - Explain:_____
_____

I certify the information I have provided to Peak Motion, LLC is accurate and truthful.

Signature_____ Date_____
THANK YOU!

Patient Authorization Record

Initials

_____ **Authorization for Treatment** –

- I hereby give authorization for the performance of such rehabilitation procedures as permitted by Washington State Statutes under the appropriate scope of practice that are, in the judgment of my Therapist, deemed necessary.

_____ **Authorization for Release of Information**

- I agree that Peak Motion, LLC may provide information from my medical record to persons involved in my medical care (please notify receptionist if you wish to further specify disclosure/release of information).
- I authorize the release of medical information necessary to obtain payment of any benefits available to me to Peak Motion, LLC for services rendered.
- I agree that Peak Motion, LLC may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment.
- **I have read "Notice of Privacy Practices" dated March 1, 2013 mandated by HIPAA.**

_____ **Authorization for Release of Payment**

- I authorize that direct payment of any benefits available to me be released to Peak Motion, LLC for services rendered. If I am paid directly, I will promptly pay Peak Motion, LLC all monies paid to me.

_____ **Patient Agreement**

- I agree to pay Peak Motion, LLC charges for services rendered to me during my course of treatment and that all payments designated as "the patient's responsibility" such as co-insurance, co-pays and deductibles are due and payable at the time of service or statement receipt.
- I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit by the statement date. If I do not pay for charges that are my responsibility, I agree to pay Peak Motion, LLC collections costs including attorney and court fees.

_____ **Medicare, Medicaid, and Similar Benefits**

- I agree that the information given to Peak Motion, LLC in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Peak Motion, LLC may give Social Security Administration or its fiscal intermediary's information necessary to process claims.

_____ **Workers Compensation**

- I agree that the information given to Peak Motion, LLC in applying for benefits under Workers Compensation is complete and accurate. I agree that Peak Motion, LLC may give intermediary's information necessary to process claims.

_____

Patient signature Date

_____

Printed patient name

_____

Signature of Legal Representative/POA Date