MAYFIELD PHYSICAL THERAPY

PATIENT INTAKE FORM

NAME:		DATE OF INJURY:	
STREET ADDRESS:		TODAY'S DATE:	
CITY/STATE/ZIP:		DATE OF BIRTH:	
HOME PHONE #:		MARITAL STATUS:	SINGLE MARRIED OTHER
CELL PHONE #:		GENDER:	MALE / FEMALE
REFERRING DOCTOR:		E-MAIL:	

Have you had any physical therapy or chiropractic treatment this calendar year? (Circle one)	Yes No	How many visits?

RESPONSIBLE PARTY

Is This a Work Injury? (Circle One)	Yes / No	Is Injury a Result of Auto Accident? (Circle One)	Yes / No
Name of Insurance Card Holder:		Date of Birth of Insurance Card Holder:	
SS# of Insurance Card Holder:		Employer of Insurance Card Holder:	

INSURANCE INFORMATION (Patient does not need to fill out below this line)

Primary Insurance:	Secondary Insurance:
Insurance Phone:	Insurance Phone:
Insurance ID#:	Insurance ID#:
Insurance Group #:	Insurance Group #:
Effective Date:	Effective Date:
____Calendar Year _____Benefit Year	_____ Calendar Year _____ Benefit Year
Copay: Co-Insurance:	Copay: Co-Insurance:
Deductible: Individual _____ Family _____	Deductible: Individual _____ Family _____
Coverage: %	Coverage: %
OOP: Individual _____ Family _____	OOP: Individual _____ Family _____
Dollar Limit: Yes/No	Dollar Limit: Yes/No
Visit Limit: Yes/No	Visit Limit: Yes/No
Combined?	Combined?
Referral Required: Yes/No	Referral Required: Yes/No
Precertification Required: Yes/No	Precertification Required: Yes/No
Precert Phone #:	Precert Phone #:
Rx For Medical Necessity? Yes/No	Rx For Medical Necessity? Yes/No

Mayfield Physical Therapy
781 Beta Drive
Suite C
Mayfield Village, OH 44143

PATIENT: _____

MEDICAL HISTORY FORM

Diagnosis as stated to you by your physician: _____ Date of onset: _____

How did this injury/exacerbation occur: _____

Have you been hospitalized for the present condition? ☐Yes ☐No If Yes, date: _____

Have you had surgery for the present condition? ☐Yes ☐No If Yes, date: _____

Have you received previous treatment for this condition? ☐Yes ☐No If Yes, date: _____

If yes, please summarize: _____

Are you currently receiving or have you received in the last 30 days any home health, medical or chiropractic services rendered to you by any other agency, organization or individual? If yes, please summarize:

_____

Are you on any medications? Please list: _____

Have you ever had any of the following? ☐ EMG ☐ CT SCAN ☐ MYELOGRAM ☐ MRI ☐ XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Diabetes	☐Yes	☐No
Headaches	☐Yes	☐No
Dizzy Spells	☐Yes	☐No
Fainting Spells	☐Yes	☐No
Epilepsy	☐Yes	☐No
Stroke	☐Yes	☐No
Pregnancy	☐Yes	☐No
Seizures	☐Yes	☐No
Asthma	☐Yes	☐No
Emphysema	☐Yes	☐No
Osteoporosis	☐Yes	☐No
Back Injury	☐Yes	☐No
Arthritis	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No
Fracture	☐Yes	☐No
Cancer	☐Yes	☐No
Pacemaker	☐Yes	☐No
Metal Implants	☐Yes	☐No
Respiratory Problems	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Hepatitis A, B, C	☐Yes	☐No
Heart Trouble	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Hernia	☐Yes	☐No
Kidney Problems	☐Yes	☐No
Bowel / Bladder Abnormalities	☐Yes	☐No
Liver / Gallbladder Problems	☐Yes	☐No
Smoking	☐Yes	☐No
Sexual Dysfunction	☐Yes	☐No
Skin Abnormalities	☐Yes	☐No
Nausea / Vomiting	☐Yes	☐No
Allergies	☐Yes	☐No
List:		
Other:		

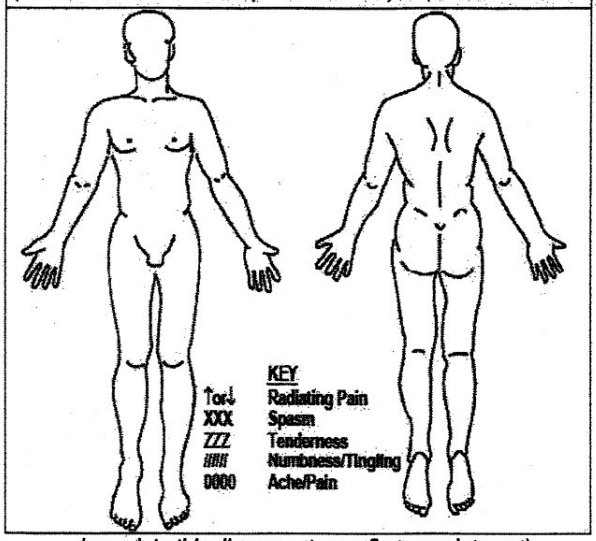
(Continue below if needed)

Ringing in your ears	☐Yes	☐No
Rheumatoid Arthritis	☐Yes	☐No
Special Diet Guidelines	☐Yes	☐No
Hypoglycemia	☐Yes	☐No
Surgeries	☐Yes	☐No
List w/ dates:		

Please check all that may apply. My pain is worse:
in the morning / during the day / at night / constant / with activity / during rest
☐ ☐ ☐ ☐ ☐ ☐

On a scale of 0 to 10,
(0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain at its best _____ and at its worse _____

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.



(complete this diagram at your first appointment)

Signature of Patient or Guardian (if patient is a minor): _____ Date: _____

Relationship to patient: ☐ self ☐ guardian ☐ other: _____

Clinician's Signature: _____ Date : _____