Peak Rehabilitation INC
PHYSICAL THERAPY

NEW PATIENT INTAKE FORM

Today's Date: _____

PATIENT INFORMATION

First Name	Middle Initial	Last Name	Preferred Name	Social Security Number

Address:	**City:**	**State:**	**Zip Code:**
Home Phone: **Cell Phone:**	**Date of Birth (mm-dd-yyyy)**	**Sex:** ☐ M ☐ F	**Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown
Date of Injury/Onset Date	**Auto Accident** ☐Yes-State__ ☐ No	**Work Related:** ☐ Yes ☐ No	

PRIMARY INSURANCE

Name of Insurance Company:	**Member ID:**	**Group #**
Policy Holder Name:	**Date of Birth:**	**Policy Holder SS#:**
Policy Holder Employer:	**Policy Holder's Contact Phone:**	**Patient Relationship to Policy Holder** ☐ Self ☐ Spouse ☐ Dependent ☐ Other

GUARANTOR INFORMATION FOR MINOR PATIENT
(PARENT WHO BRINGS THE PATIENT FOR TREATMENT)

Parent Name:	**Parent SS#:**	**Parent DOB:**
Name of Employer:	**Employer Phone:**	**Parent Cell:**

PATIENT EMPLOYER INFORMATION

Employer Name:	**Employer Phone:**	**Employment Status:** ☐ None ☐ FT ☐ PT ☐ Self-Emp ☐ Retired ☐ Student	
Address:	**City:**	**State:**	**Zip Code:**

EMERGENCY CONTACT INFORMATION

Contact Name: **Can We Speak to this Person?** ☐ Yes ☐ No	**Home Phone:** **Cell Phone:**	**Relationship** ☐ Spouse ☐ Mother/Father ☐ Relative ☐ Friend

PHYSICIAN INFORMATION

Name of Referring Physician:	**Telephone #**	
Name of Primary Care Physician:	**Telephone #**	

FINANCIAL INFORMATION

Thank you for choosing Peak Rehabilitation, Inc for your physical therapy and rehabilitative needs. The services you have elected to participate imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

We expect payment at the time of service of any deductible, co-payment/co-insurance as determined by your contract with your insurance carrier. Many insurance companies have stipulations that may affect your coverage. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue therapy past your approved period, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to Peak Rehabilitation, Inc. I authorize my insurer to pay any benefits directly to Peak Rehabilitation, Inc. I agree to pay Peak Rehabilitation, Inc the full and entire amount of all bills incurred by me or my dependant, and if applicable, any amount due after payment has been made by my insurance carrier.

Signature: _____ Date: _____

CONSENT FOR TREATMENT, AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

I hereby authorize Peak Rehabilitation, Inc. through its appropriate personnel, to perform or have performed upon me or dependant, assessment and treatment procedures relating to the diagnosis stated by my referring physician.

I hereby authorize Peak Rehabilitation, Inc. to release to the appropriate agencies, any information acquired in the course of my or my dependant's examination and treatment.

I hereby authorize Peak Rehabilitation, Inc. to submit my insurance claims for health benefit payment and submit any appeal that may be necessary when a denial of benefits is issued.

I further authorize my insurance company to send any and all payment for services rendered at Peak Rehabilitation, Inc. to Peak Rehabilitation, Inc. 1660 Washington Street, Jefferson, GA 30549

Signature: _____ Date: _____

INTRAMUSCULAR MANUAL THERAPY (IMT) /TRIGGER POINT DRY NEEDLING (TDN) CONSENT

IMT/TDN involves placing a small needle into the muscle at the trigger point which is typically in an area where the muscle is tight and tender; with the intent of causing the muscle to contract and release, improving the flexibility of the muscle and decreasing symptoms. The performing therapist will not stimulate any distal or auricular points during the dry needling treatment.

IMT/TDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint pain and may increase muscle performance. Like any treatment, there are possible complications. While complication is rare in occurrence, it is recommended you read through the possible risks prior to giving consent for treatment.

RISKS OF THE PROCEDURE:

Risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood, require blood anticoagulants or any other conditions that may have an adverse effect to needle punctures. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from IMT/TDN is unlikely.

Do you have any known disease or infection that can be transmitted through bodily fluids? **YES** **NO**

If you answered yes, please discuss with your practitioner.

_____	_____	_____
Printed Name	**Signature**	**Date**

Peak Rehabilitation INC
PHYSICAL THERAPY

PAST MEDICAL HISTORY FORM

Patient Name _____ **Date:** _____

Describe your current symptoms: _____

Have you had these symptoms before? ☐ Yes ☐ No

Check how the injury occurred:

☐ Work related injury
☐ Motor vehicle accident
☐ Unknown cause of injury
☐ Recurrence of previous injury
☐ Injury related to lifting
☐ Athletic/recreational injury
☐ Injury related to fall
☐ Surgery/Date_____

Do you have, or have had any of the following conditions?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergy to Aspirin	☐	☐
Chest Pain/Angina	☐	☐	Allergy to heat	☐	☐
Heart disease	☐	☐	Allergy/poor tolerance cold	☐	☐
Heart attack	☐	☐	Other allergies _____	☐	☐
Heart palpitations	☐	☐	Hernia	☐	☐
Pacemaker	☐	☐	Seizures	☐	☐
Headaches	☐	☐	Metal Implants	☐	☐
Kidney problems	☐	☐	Dizziness/Fainting	☐	☐
Are you pregnant?	☐	☐	Recent Fractures	☐	☐
Cancer	☐	☐	Surgeries	☐	☐
Osteoporosis	☐	☐	Skin Abnormalities	☐	☐
Bowel/Bladder abnormalities	☐	☐	Sexual Dysfunction	☐	☐
Urine Leakage	☐	☐	Nausea/vomiting	☐	☐
Asthma/Breathing difficulties	☐	☐	Ringing in your ears	☐	☐
Liver/Gallbladder problems	☐	☐	Rheumatoid Arthritis	☐	☐
Smoking	☐	☐	Special diet guidelines	☐	☐
Other _____	☐	☐	Stroke/CVA	☐	☐

If you answered YES to any of the above, please explain briefly and give approximate date:

_____

_____

_____

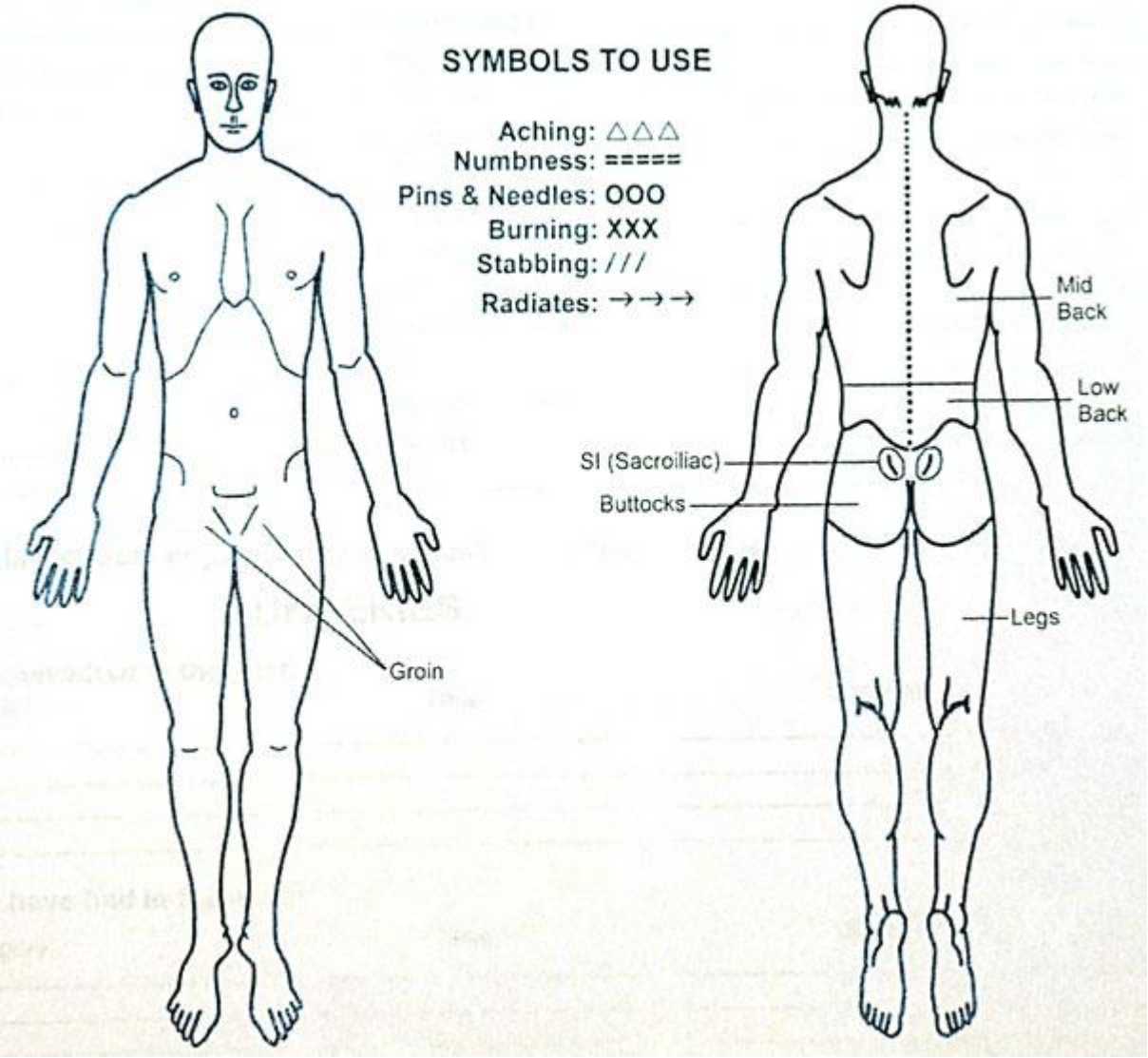
Are you presently taking Medication? ☐ Yes ☐ No

Please list name of medication with dosage:_____

_____

_____

If you are having pain, please rate the intensity on a scale of 0-10, with 0 being no pain and 10 being the worst pain: _____



_____ _____ _____

Patient Signature Parent Signature if patient is minor Date