MR #: Patient Name:

CAROLINA PHYSICAL THERAPY PATIENT DATA SHEET				
First:	MI:	Last:		
Date of Birth:	Age:	Gender: Male Female		
Physical Address:		Mailing Address:		
Phone Numbers:	OK To Call Bes	st Time To Call		
Home:				
Work:				
Cell:				
May we send you text me above?		appointment reminders to the number(s) listed		
May we send you text me the number(s) listed abo		eting Materials, including Patient review requests to No		
By marking "Yes" above of unauthorized access t		that text messages may NOT be secure, with a risk		
May we send you emails relating to your care with us? Yes No By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information. Email:				
Preferred language:		Interpreter required? Yes		
Date of Injury:	R	Referring Physician:		
Injury Area:	Auto	or Work Accident: Auto Work N/A		
State Where Accident Occured:				
Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days?				
Are you currently receiving the last 60 days?	ng or have you ree	ceived other therapy services in		
Marital Status:				
Married Single	Divorced	Widowed Separated Unknown		
Student Status:				
Full-Time Part-	Time 🗌 None			

MR #: Patient Name:

EMPLOYMENT STATUS					
Employment Status: Active Military Full-Time None Part-Time Retired Self Employed					
Employer: Occupation:					
Address:					
Phone:					
Employer: Occupation:					
Address:					
Phone:					
INSURANCE INFORMATION					
Primary Insurance:					
Policy Holder's Name: Holder's Birth Date:					
Policy or Certificate #: Group #:					
Policy Holder's Employer:					
Secondary Insurance:					
Policy Holder's Name: Holder's Birth Date:					
Policy or Certificate #: Group #:					
Policy Holder's Employer:					

MR #: Patient	Name:				Page: 3/4
How	did you hear abou	It us?)		
	Physician		Hospital	Marketing Ad - Print	
	Employer		Cross Referral	Marketing Ad - TV	
	Case Manager		Friend - Word of Mouth	Marketing Ad - Billboard	
	Former Patient		Attorney	Marketing Ad - Direct Mail - Email	
	Adjustor		Self	Marketing Ad - Facebook	
	School		Screens - Open Houses	Marketing Ad - Other	
Spe	cify if other :				

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS					
Name	Phone	Work	Cell	Fax	Туре

ve access to my medical and billing re	cords:
Relationship	
Relationship	
	Date
	Relationship

MR #:
Patient Name:

PATIENT INTAKE AND CONSENT FORM

Internal Use Only:	A/C#	Name	А/С Туре	Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at: CAROLINA PHYSICAL THERAPY

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials**:

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

LIABILITY

I know and agree that: CAROLINA PHYSICAL THERAPY is not responsible for loss or damage to personal valuables.

Initials:

WAIVER AND RELEASE

I hereby release, discharge and acquit: CAROLINA PHYSICAL THERAPY its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: CAROLINA PHYSICAL THERAPY I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices.

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.

NOTICE OF PRIVACY/PATIENT BILL OF I acknowledge receipt of Notice of Privacy I acknowledge receipt of the Statement of	Practices.	Initials: Initials:		
I certify that all of the information provided herein is true and correct.				
Patient/Guardian Signature	Witness Signature	Date		

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of CAROLINA PHYSICAL THERAPY. This form must be completed in its entirety and must be provided to CAROLINA PHYSICAL THERAPY prior to initiation of therapy services. **Revised 4.5.21**

Medical History Form

Patient Name:		.Today's Date:		
Referring Physician:		Date of Birth:		Age:
Primary Care Physician:		Date of Injury or Onset:		
Date of Next Physician Appointment:				
Reason for Therapy:				
Cause of Injury or Onset: Accident		r: If Other, plea	aa avalain:	
		i. ii Other, pie	ase explain.	
Have you been hospitalized for the pres			, date:	
Did you have surgery for this condition If Yes, surgery type:	1? 🗌 Yes 🗌 No	If Yes, date:		
Are you currently receiving any other c If Yes, please describe:	are for the condition n	nentioned above?	∐Yes ∐No	
Have you ever received therapy in the p	past for the condition i	mentioned above?	Yes No If Y	es, date:
Describe previous treatment:				
Previous Treatment: Successful Un	successful			
Have you fallen in the last year?		-		u injured? □ Yes □ No ? □ Yes □ No
What are your personal goals/outcome	s you hope to achieve	from therapy?		
Describe your general health: Excel	llent 🗌 Good 🔲 Fair	Poor Do ye	ou smoke or use	tobacco? 🗌 Yes 🗌 No
DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)				
Allergies 🗌 Latex 🗌 Other	Dizziness Dizziness			
🗌 Anemia	☐ Epilepsy or Seiz	ure Disorder	🗌 Metal Impla	ints
Anxiety or Panic Disorders	Fainting			
🗌 Arthritis 🗌 OA 📋 RA	☐ Fatigue or Weak	ness	Multiple Sc	lerosis
🗌 Asthma	Fever or Chills		🗌 Nausea / Vo	omiting
☐ Use of Blood Thinners	Fractures			sis
Bowel or Bladder Disorder	☐ Headaches		Pacemaker	
☐ Bleeding Disorder	Head Injury or C	oncussion	Parkinson's	s Disease
Cancer	Hearing Impairment		Peripheral Vascular Disease	
🗌 Chronic Cough	☐ Heart Disease or	Heart Attack	Respiratory	or Breathing Problems
	🗌 Hepatitis 🛛 A	□В□С	Ringing in	Ears
Congestive Heart Failure	🗌 Hernia		Sexual Dys	sfunction
Currently Pregnant	Blood Pressure	🗌 High 🔲 Low	Skin Abnor	malities
Deep Vein Thrombosis (DVT)	HIV or AIDS		Stroke or T	IA
Depression	🗌 Hypoglycemia		Thyroid Pro	oblems
🗌 Diabetes 🔤 Type I 🔄 Type II	Diabetes Type I Type II Hypersensitivity to Hot or Cold		☐ Tuberculosis	
List any other medical problems and explain:				

Medical History Form

Medication List					
Name of Medication	Dosage	Frequency			
Check Box if Medication List provided separately.					
1.			☐ Injection ☐ Oral ☐ Topical ☐Other		
2.			☐ Injection ☐ Oral ☐ Topical ☐Other		
3.			☐ Injection ☐ Oral ☐ Topical ☐Other		
4.			☐ Injection ☐ Oral ☐ Topical ☐Other		
5.			☐ Injection ☐ Oral ☐ Topical ☐Other		
6.			☐ Injection ☐ Oral ☐ Topical ☐Other		
7.			☐ Injection ☐ Oral ☐ Topical ☐Other		
8.			☐ Injection ☐ Oral ☐ Topical ☐Other		
9.			☐ Injection ☐ Oral ☐ Topical ☐Other		
10.			☐ Injection ☐ Oral ☐ Topical ☐Other		
11.			☐ Injection ☐ Oral ☐ Topical ☐Other		
12.			☐ Injection ☐ Oral ☐ Topical ☐Other		
Over the Counter Medications (check all that apply): Aspin Cough Medicine Allergy Relief Laxative Diet Pills			Cold Medicine:		
Pain ScaleRate the severity of your pain by circling a box on the following scale.No PainWorst Pain12345678910On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location.KEY:A = AchingB = BurningN = Numbness O = Other					
Signature of Patient:		DOB:			
Printed Name of Patient:		Date:			