PLYMOUTH
PHYSICAL THERAPY SPECIALISTS
Orthopedics • Sports Medicine • Industrial Rehabilitation

**RETURNING PATIENT**

**Patient Name: _____ Clinic: _____**
(Please print clearly)

**What Was The #1 Reason You Returned To Plymouth Physical Therapy Specialists?**

**Please check only one box, Thank You!**

- ☐ **Pleased with previous treatment results**
- ☐ **Confidence in your previous therapist (Name)_____**
- ☐ **All Staff was attentive and accessible**
- ☐ **Friendly staff/pleasant environment**
- ☐ **Cleanliness of the facility**
- ☐ **Close to home or work**
- ☐ **Doctors specifically referred to PPTS**
- ☐ **Convenient hours**

**May we add you to our email list to receive periodic newsletters, updates, and events?**

**Please Circle: Y N**

**Email Address**_____
(Your email will remain confidential) Please print clearly.

# PLYMOUTH PT SPECIALISTS
# PATIENT INTAKE AND CONSENT FORM

**Internal Use Only:** Account # _____ Account Type _____ Office # _____

First Name _____ MI _____ Date of Injury/Onset _____ Today's Date _____
Last Name _____ Date of Birth _____ Age _____
Address _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W
_____ Home Phone _____
City _____ State ____ Zip _____ Work Phone _____

Responsible Party _____ Cell Phone _____
Address _____ Injury Area _____
City _____ State ____ Zip _____ Accident Related: ☐ Yes ☐ No
Phone Number _____ If Accident: ☐ Auto ☐ Work ☐ Other
Relationship to Responsible Party _____ Nature of Accident _____

Employer _____ SS# _____
Address _____ Occupation _____
City _____ State ____ Zip _____ Contact at Employer _____

Referring Physician _____ Phone Number _____

Primary Insurance _____ Insured Name _____
Group # _____ ID # _____ Address _____ City _____
Insured Employer _____ State _____ Zip _____ Phone _____
Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: ☐ M ☐ F

Second Insurance _____ Insured Name _____
Group # _____ ID # _____ Address _____ City _____
Insured Employer _____ State _____ Zip _____ Phone _____
Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: ☐ M ☐ F

Emergency Contact _____ Daytime Phone Number _____

Are you receiving or have you recently received home health services? ☐ Yes ☐ No
Are you receiving or have you recently received other therapy services? ☐ Yes ☐ No

Please initial:

**CONSENT TO TREATMENT:** I consent to rehabilitation and related services at PLYMOUTH PT SPECIALISTS. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____

**TREATMENT OF MINORS:** I, as 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 PLYMOUTH PT SPECIALISTS is not responsible for loss or damage to personal valuables. _____

**WAIVER AND RELEASE:** I hereby release, discharge and acquit PLYMOUTH PT SPECIALISTS, it's 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 PLYMOUTH PT SPECIALISTS and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. 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. _____

**NOTICE OF PRIVACY:** I acknowledge receipt of Notice of Privacy Practices. _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Witness Signature _____

PLYMOUTH
PHYSICAL THERAPY SPECIALISTS
Orthopedics • Sports Medicine • Industrial Rehabilitation

**Patient Name:**_____

## MEDICAL HISTORY

**Allergies:** _____
_____

Are you currently seeing any of the following?

YES NO Medical Doctor (MD) YES NO Chiropractor YES NO Dentist
YES NO Osteopath (DO) YES NO Physical Therapist YES NO Podiatrist

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc): _____
_____

Please indicate if you have EVER been diagnosed as having any of the following conditions: (answer all questions)

Y N Cancer. If yes, describe what kind:_____
Y N Heart problems_____
Y N Pace maker_____
Y N Circulation problems_____
Y N High blood pressure_____
Y N Stroke_____
Y N Respiratory problems_____
Y N Infectious disease_____
Y N Hepatitis_____
Y N Tuberculosis_____
Y N Anemia_____
Y N Thyroid problems_____
Y N Kidney disease_____
Y N Diabetes_____
Y N Epilepsy_____
Y N Rheumatoid arthritis_____
Y N Other arthritic conditions_____
Y N Currently pregnant_____
Y N Metal or plastic implants_____
Y N Osteoporosis_____

Please list ALL surgeries and dates_____

**Patient Name:_____**

What are your symptoms at the present time?_____
What relieves your symptoms?_____

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

Y N Aspirin
Y N Tylenol
Y N Advil/Motrin/Ibuprofen
Y N Laxatives
Y N Decongestants
Y N Antihistamines
Y N Antacid
Y N Vitamins/mineral supplements
Y N Other_____

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or patches):_____

---

Have you recently noted:

Y N Weight loss/gain
Y N Nausea/vomiting
Y N Fatigue
Y N Weakness
Y N Fever/chills/sweats
Y N Numbness or tingling

**I have completed this form to the best of my knowledge and have not withheld any information.** Form reviewed with patient? ___Yes ___No

_____ _____
Patient Signature Date Therapist Signature Date