# Health Intake and Attendance Policy

**PATIENT INFORMATION:**

Print Name (Last) _____ (First) _____ (MI) _____

Mailing Address _____APT#_____

City/State/ZIP_____Phone_____Other Phone _____Sex: F M

Date Of Birth_____Age_____Occupation_____

Employer Name_____Work Phone_____

Employer Address_____City/State/ZIP_____

**REFERRAL INFORMATION:**

Referring Provider's name? _____ Phone _____ Fax _____

Primary Care Provider _____ Phone _____ Fax _____

Insurance/s? _____ins. # _____

*Secondary* or *Supplemental*? (circle one)_____ # _____

**D**ate of injury/diagnosis/condition: _____**H**ow were you injured? _____

**D**id you have surgery for this condition/injury? Y N **If Yes**, date of surgery _____

**H**ave you received Speech/physical/occupational/massage/respiratory Therapy here before? Y N

**H**ave you had any Therapy anywhere this year? Y N **H**ow many visits for any Therapy this year or this L&I claim? _____

**MEDICAL HISTORY:**

**Please list any known allergies**_____

**Have you ever been diagnosed with any of the following**: (circle any)

| | | | | |
|---|---|---|---|---|
| **C**ancer | **H**eart Problems | **H**igh Blood Pressure | **C**irculation Problems | **A**sthma |
| **T**hyroid Problems | **D**iabetes | **S**troke | Arthritic Conditions | **H**epatitis |
| **T**uberculosis | **K**idney Disease | **B**lood Clots | **O**steoporosis | **M**ultiple Sclerosis |

**Other**_____

**Please list any recent Surgeries/Hospitalizations within the last 5 years, include the approximate date and reason:**

1._____ 2._____

3._____ 4._____

**Any other past injuries or surgeries that may be relevant to the reason for your appointment today:** _____

_____

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**Have you taken any of the following medications within the last week**: (check each that apply)

- Aspirin
- Tylenol
- Anti-inflammatories (Advil/Motrin/Ibuprofen/etc…)
- Anti-coagulants (ie: warfarin)
- Vitamins/mineral supplements/herbal remedies

**Did you provide a copy of a list of medications?** Y N

***If not*, list here any physician prescribed medications you're currently taking** (including: pills, injections, skin patches, etc…)

_____

_____

***Smoking and or drinking alcohol may impact your healing in ways that you can discuss with your therapist during your appointment and this information is useful in setting up your treatment plan…***

Do/did you smoke? Y N If yes, how much? _____ For how many years? _____ If quit, when? _____

Do you drink alcohol? Y N If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____
How many days per week? _____

**Please circle any of the following that are NEW, UNUSUAL, or ATYPICAL for you:**

| | | | |
|---|---|---|---|
| **W**eight loss/gain | **J**oint/muscle swelling | **E**asy bruising | **D**ifficulty breathing |
| **W**eakness | **R**egular cough | **A**rm/leg swelling | **N**umbness and/or tingling |
| **H**eart racing in your chest | **D**ifficulty swallowing | **C**onstipation/diarrhea | **U**rinary incontinence/problems |
| **S**tress at home or work | **E**ye/sight changes | **S**kin rash | **P**roblems sleeping from pain |

## ATTENDANCE POLICY – *PLEASE READ CAREFULLY*

***We** are committed* to providing you with excellent care in a timely fashion, with compassion and consideration of your individual therapy needs. Your prescribing/referring provider is expecting you to fully participate in your care for the optimal outcome, so it is essential that we discuss a treatment plan that works well with your schedule and individual needs, to reach your and your physician's reasonable expectations for therapy. Once a treatment plan is created, it is imperative that you attend your appointments, are on-time, and that you understand and **DO** your **H**ome **E**xercise **P**rogram. *In* the event of frequent No Shows or Cancellations, your future appointments will be removed from our appointment book and you will be asked to see your prescribing/referring provider or physician before scheduling further appointments.

*By* signing I, (*print name*) _____, agree to the attendance policy and confirm that all health information provided is accurate to the best of my knowledge.

Patient's Signature: _____Date:_____