PATIENT INITIAL INTAKE

PERSONAL INFORMATION:

*Patient's Name (Last, First, MI): _____

*Date of Birth: _____ *Address - Street: _____

*City: _____ Zip: _____

Age: _____ Gender: _____ Marital Status: _____

Social Security Number: _____ State ID Number: _____

*Contact Information: Preferred Contact Info? Place an X:

Home: _____ ( )

Work: _____ ( )

Cell: _____ ( )

Email: _____ ( )

*Referring MD: _____ Contact #: _____

Primary Care MD: _____ Contact #: _____

FOR MINORS / LEGAL REPRESENTATIVE:

Name of Parent / Guardian / POA: _____

Relation: _____ Contact # / Info: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relation: _____ Contact #: _____

*Would you like appointment reminders? ☐ No If Yes, Through: ☐ E-mail ☐ Call ☐ Text Message

INSURANCE INFORMATION:

*Primary Insurance Name: _____

*Insurance ID #: _____ *Group #: _____

If other than Patient: Insurance Holder: _____ *DOB:* _____

Relation to Patient: _____ *Employer:* _____

AAA Physical Therapy, LLC
p. 443.979.7171 | f. 443.864.5095 | e. admin@aaaphysicaltherapy.com
6955 Oakland Mills Rd. Ste E, Columbia, MD 21045

*Secondary or Supplemental Insurance Name: _____

Insurance ID #: _____ Group #: _____

If other than Patient: Insurance Holder: _____ *DOB:* _____

Relation to Patient: _____ *Employer:* _____

*Is patient's condition secondary to:

☐ Auto Accidents ☐ Work-related Accident ☐ Others ☐ NA

Date of Injury / Accident: _____

FOR AUTO ACCIDENTS (IF APPLICABLE): Auto Insurance Name: _____

Claim #: _____ Claim Manager/Adjuster: _____

Claim Address: _____ Contact #: _____

FOR WORK-RELATED INJURY (IF APPLICABLE):

Insurance Name: _____ Case #: _____

Case Manager: _____ Contact #: _____

WORK INFORMATION (Optional, *required* for Worker's Compensation):

Employer: _____ Contact #: _____

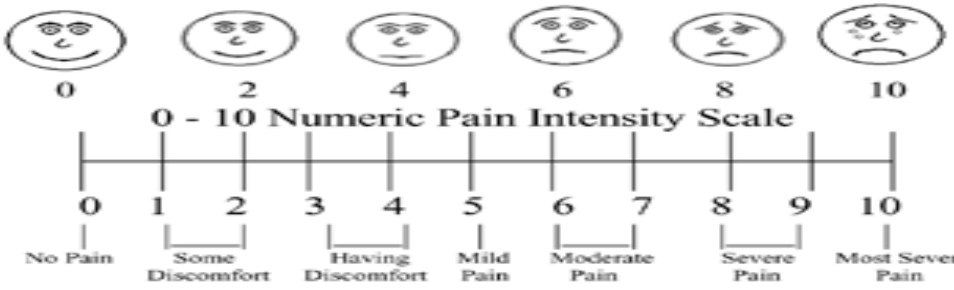
Address: _____

Have you had physical therapy before? ( ) No If Yes, Where? _____

How did you learn about AAA Physical Therapy, LLC? _____

Patient Signature: _____ Date: _____

PATIENT HISTORY QUESTIONNAIRE



☐ 0 ☐ 6-7

☐ 1-2 ☐ 8-9

☐ 3-4 ☐ 10

☐ 5

AAA Physical Therapy, LLC
p. 443.979.7171 | f. 443.864.5095 | e. admin@aaaphysicaltherapy.com
6955 Oakland Mills Rd. Ste E, Columbia, MD 21045

Please identify your main concern: _____

_____

Body part of where you feel your symptoms:

☐ Neck ☐ Shoulder ☐ Elbow ☐ Arm ☐ Wrist ☐ Hand
☐ Chest ☐ Upper Back ☐ Lower Back ☐ Pectoral Muscles
☐ Groin ☐ Thighs ☐ Knee ☐ Calves ☐ Ankle ☐ Foot
☐ Other Body Part: _____

Side of where you feel your symptoms:
☐ LeftSide ☐ Right Side ☐ Both Sides

How are your job duties and other physical requirements / functionality impacted?

_____

_____

Place an X on any of the following activities that you experience in difficulty or pain with:

☐ Bending ☐ Childcare ☐ Cooking ☐ Dressing ☐ Driving ☐ Gripping
☐ Grooming ☐ Laundry ☐ Lifting ☐ Getting in/out of bed ☐ Getting in/out of car
☐ Reaching ☐ Riding the car ☐ Shopping ☐ Sitting ☐ Sleeping ☐ Standing
☐ Walking ☐ Writing ☐ Others: Please specify:

_____

Please describe all hobbies/recreational activities that you participate in and having difficulty with:

_____

MEDICAL / SURGICAL HISTORY:			
☐ Arthritis	☐ Growth Problems	☐ Kidney Problems	☐ Osteoporosis
☐ Blood Disorder	☐ Head Injury	☐ Low Blood Sugar	☐ Parkinson's Disease
☐ Cancer	☐ Heart Disease	☐ Lung Problems	☐ Seizures/Epilepsy
☐ Circulation Problem	☐ High Blood Pressure	☐ Migraines	☐ Skin Diseases
☐ Diabetes	☐ High Cholesterol	☐ Multiple Sclerosis	☐ Stomach Problems
☐ Fractures	☐ Infectious Disease	☐ Muscular Dystrophy	☐ Stroke
			☐ Thyroid Problems

Others: _____

Surgeries (What and When?): _____

Allergies: _____

Patient Authorization Record

Initial Below:

	Authorization for Treatment ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by Maryland Statutes under the appropriate scope of practice are, in the judgment of my physical therapist, deemed necessary. (see separate sheet for details of treatment procedures)
	Authorization for Release of Information ➢ I agree that AAA Physical Therapy, LLC may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to AAA Physical Therapy, LLC for services rendered. ➢ I agree that AAA Physical Therapy, LLC may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to AAA Physical Therapy, LLC for services rendered.
	Patient Agreement ➢ I agree to pay AAA Physical Therapy, LLC charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges, which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay AAA Physical Therapy, LLC collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ➢ I agree that the information given to AAA Physical Therapy, LLC in applying for benefits under Medicare and Medicaid services are complete and accurate. I agree that AAA Physical Therapy, LLC may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation ➢ I agree that the information given to AAA Physical Therapy, LLC in applying for benefits under Workers Compensation is complete and accurate. I agree that AAA Physical Therapy, LLC may give intermediary's information necessary to process claims.

_____ _____

Patient Signature Date

_____

Printed Patient Name

Please Click To Submit Form

_____ _____

Signature of Legal Representative/POA Date