MR #: Patient Name:

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CLEVELAND 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:					
<u>Cell:</u>					
	essages for your lo	appointment reminders to the number(s) listed			
May we send you text m the number(s) listed abo		aeting Materials, including Patient review requests to No			
By marking "Yes" above of unauthorized access		I that text messages may NOT be secure, with a risk on			
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:	F	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 receive the last 60 days?	ng or have you re	ceived other therapy services in			
Marital Status:					
Married Single	Divorced	Widowed Separated Unknown			
Student Status:					
🗌 Full-Time 🗌 Part	t-Time 🗌 None	e			

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

Office

Initials:

CONSENT TO TREATMENT

I consent to rehabilitation and related services at: CLEVELAND 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: CLEVELAND PHYSICAL THERAPY is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE

I hereby release, discharge and acquit: CLEVELAND 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: CLEVELAND 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 RIGHTS I acknowledge receipt of Notice of Privacy Practices. I acknowledge receipt of the Statement of Patient Rights. 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 CLEVELAND PHYSICAL THERAPY. This form must be completed in its entirety and must be provided to CLEVELAND 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	ese explain [.]	
Have you been hospitalized for the pres			date:	
Did you have surgery for this condition If Yes, surgery type:	!? ∐ 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 Describe previous treatment:	past for the condition i	mentioned above? [Yes No If Y	es, date:
Previous Treatment: □Successful □Un	euccosoful			
Have you fallen in the last year?		many times?	If Yos wore ve	u injured? 🗌 Yes 🗌 No
Do you feel unsteady when standing or			orry about falling	
What are your personal goals/outcome	s you hope to achieve	from therapy?		
Describe your general health: Excel	llent 🗌 Good 🔲 Fair	Poor Do yo	ou smoke or use t	tobacco? 🗌 Yes 🗌 No
DO YOU CURRENTLY HAVE OR HAVE A H	IISTORY OF ANY OF THE	FOLLOWING COND	TIONS? (check all	that apply)
Allergies 🗌 Latex 🗌 Other	Latex Other Dizziness Kidney Problems			
Anemia	Epilepsy or Seize	ure Disorder	🗌 Metal Impla	nts
☐ Anxiety or Panic Disorders	Fainting			
🗌 Arthritis 🗌 OA 🗌 RA	☐ Fatigue or Weak	ness	☐ Multiple Sclerosis	
☐ Asthma	Fever or Chills		🗌 Nausea / Vo	omiting
☐ Use of Blood Thinners	Fractures		Osteoporos	sis
Bowel or Bladder Disorder	Headaches		Pacemaker	
☐ Bleeding Disorder	Head Injury or C	oncussion	Parkinson's	s Disease
Cancer	🗌 Hearing Impairm	ent	🗌 Peripheral V	/ascular Disease
Chronic Cough	☐ Heart Disease or	Heart Attack	Respiratory	or Breathing Problems
	🗌 Hepatitis 🛛 A	ВС	🗌 Ringing in I	Ears
Congestive Heart Failure	🗌 Hernia		Sexual Dys	function
Currently Pregnant	Blood Pressure	🗌 High 🔲 Low	🗌 Skin Abnor	malities
Deep Vein Thrombosis (DVT)	HIV or AIDS		Stroke or T	A
Depression	🗌 Hypoglycemia		Thyroid Pro	oblems
🗌 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): Aspirin/Ibuprofen Antacids Sleeping Aids Cold Medicine:					
Pain ScaleRate the severity of your pain by circling a box on the following scale.No 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:			