



PATIENT INTAKE FORM

Male  Female

Last Name \_\_\_\_\_ MI \_\_\_\_\_ First Name \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-Mail \_\_\_\_\_ Referred by \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Ext. \_\_\_\_\_

**Appointment Reminder:** Call  Text  Email  **How would you like to receive statements?** Email  Mail

EMPLOYMENT INFORMATION

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Job Duties \_\_\_\_\_

EMERGENCY CONTACT

Marital Status \_\_\_\_\_

Primary Contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Secondary Contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

PHYSICIAN INFORMATION

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Fax # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

INSURANCE INFORMATION

Insurance Carrier \_\_\_\_\_ Insurance Plan \_\_\_\_\_ Phone# \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

**Assignment of Insurance Information and benefits**

**I hereby authorize the insurance carrier listed above to make payments directly to Catalyst Physical Therapy and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. I further understand that if I enroll in another insurance plan, it is my responsibility to notify Catalyst Physical Therapy; otherwise I will be responsible for payment.**

Name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_



## INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient:

Physical therapy involves the use of many different types of physical therapy evaluation and treatment. At Catalyst Physical Therapy, we use a variety of “hands-on” procedures, techniques and occasional modalities to help use to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Due to the nature of “hands-on” evaluation and treatment techniques used at Catalyst Physical Therapy, physical contact with the injured body part and those parts related to the injury is required. Occasionally, we may ask you to expose the injured body part for complete analysis and treatment.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition for which you are seeking treatment. There is also a risk that your treatment may cause discomfort or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during treatment session.

Therapeutic exercises are an integral part of our physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them and allay any fears.

**I understand there are risks and benefits associated with the Physical Therapy program as outlined to me, and I wish to proceed.**

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Print Name

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Signature

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Date

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Witness/Catalyst representative



### **Financial Policy Acknowledgement**

I have received the Financial Policy notice and I have read and understand my financial obligations.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **Privacy Practices Acknowledgment**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **Appointment Policy Acknowledgement**

I have received the Appointment Policy notice and I have read and understand our policy.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

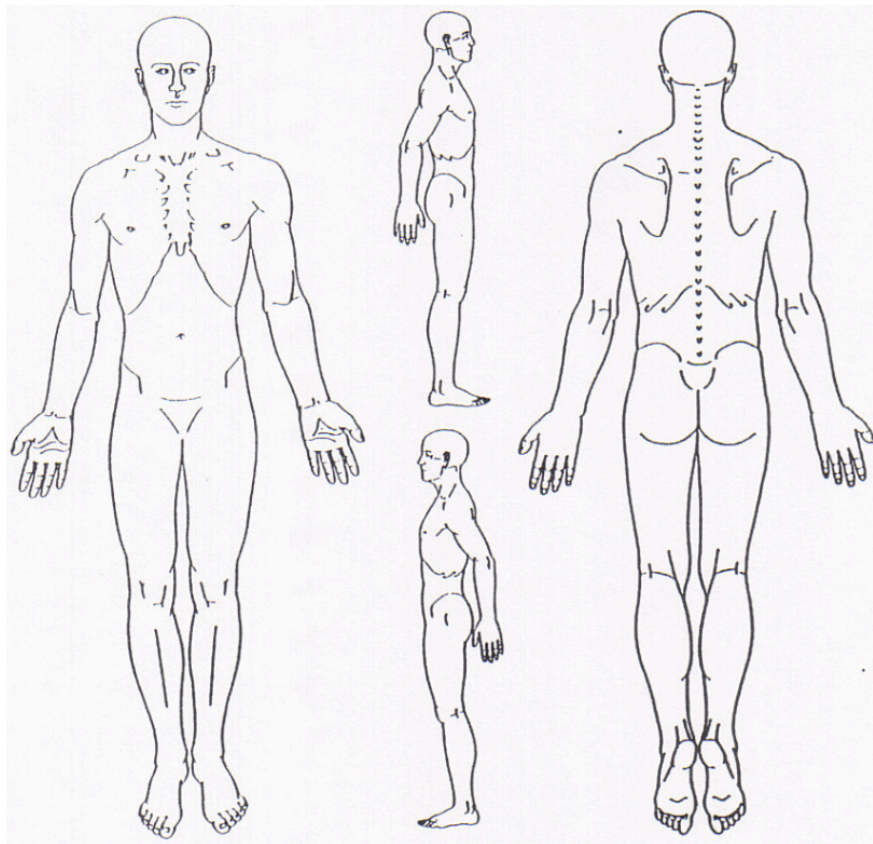


## Pain Drawing Assessment

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Draw your location of pain on the body outlines. Include all affected area. Mark the severity and description of your pain at the bottom of the page.



NO PAIN    1    2    3    4    5    6    7    8    9    10    INTOLERABLE PAIN  
CIRCLE YOUR PAIN ESTIMATE

Ache

Burning

Numbness

Pins & Needles

Stabbing

Signature: \_\_\_\_\_

Date: \_\_\_\_\_