

PT BOULDER | INTAKE PACKET

PATIENT INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Phone ( ) \_\_\_\_\_ - \_\_\_\_\_  Mobile  Home  Work

Email \_\_\_\_\_  
(Email is used for direct communication only, will not be used for marketing purposes)

Preferred Method of Contact:  Email  Phone call  Text

Address \_\_\_\_\_

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

Referred by \_\_\_\_\_

Occupation/Sport \_\_\_\_\_

EMERGENCY CONTACT

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

PARENT/GUARDIAN INFORMATION (if applicable)

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Parental Consent for Treatment:** As parent and/or legal guardian of \_\_\_\_\_,  
I authorize Nicole Haas, PT, DPT, OCS to evaluate and treat while I am not present.

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

CURRENT INJURY HISTORY

What issue(s) are you coming to PT for? \_\_\_\_\_

When did the injury or symptoms first appear? \_\_\_\_\_

How did the injury/symptoms occur? \_\_\_\_\_

What are your current symptoms (pain/burning/numbness ache) and where are they on your body? \_\_\_\_\_

Please list your level of pain using a scale of 0 – 10 (0= no pain, 10= unbearable pain)

Current \_\_\_\_ /10 At it's worst (highest level) \_\_\_\_ / 10 At it's best (lowest level) \_\_\_\_ /10

Did you have x-rays/MRI/CT scan of this body part? If yes, please indicate date/ findings \_\_\_\_\_

Have you had surgery for this condition? If so, please indicate type/ date/ name of surgeon \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent / Guardian Signature (if applicable) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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## GENERAL HEALTH HISTORY

To ensure that you receive a thorough and complete evaluation, please provide important background information on this form. If you are unclear regarding any of these questions, please leave it blank to prompt discussion during evaluation.

Do you currently have or have you ever had any of the following?

Are you pregnant?	<input type="checkbox"/> N/A	<input type="checkbox"/> yes	<input type="checkbox"/> no	Numbness/tingling	<input type="checkbox"/> yes	<input type="checkbox"/> no
Asthma/Lung disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no		Osteoporosis	<input type="checkbox"/> yes	<input type="checkbox"/> no
Cancer	<input type="checkbox"/> yes	<input type="checkbox"/> no		Recent Fractures	<input type="checkbox"/> yes	<input type="checkbox"/> no
Chest pain/palpitations	<input type="checkbox"/> yes	<input type="checkbox"/> no		Rheumatoid Arthritis	<input type="checkbox"/> yes	<input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no		Seizures	<input type="checkbox"/> yes	<input type="checkbox"/> no
Difficulty with swallowing	<input type="checkbox"/> yes	<input type="checkbox"/> no		Shortness of breath/difficulty breathing	<input type="checkbox"/> yes	<input type="checkbox"/> no
Dizziness/light headedness	<input type="checkbox"/> yes	<input type="checkbox"/> no		Stroke/CVA	<input type="checkbox"/> yes	<input type="checkbox"/> no
Fainting/ loss of consciousness	<input type="checkbox"/> yes	<input type="checkbox"/> no		Surgeries	<input type="checkbox"/> yes	<input type="checkbox"/> no
Headaches	<input type="checkbox"/> yes	<input type="checkbox"/> no		Swelling in feet or hands	<input type="checkbox"/> yes	<input type="checkbox"/> no
Heart Attack/ Pacemaker	<input type="checkbox"/> yes	<input type="checkbox"/> no		Unexplained bowel/ bladder changes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Heart Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no		Unexplained change in appetite	<input type="checkbox"/> yes	<input type="checkbox"/> no
Hernia	<input type="checkbox"/> yes	<input type="checkbox"/> no		Unexplained fatigue (unusual)	<input type="checkbox"/> yes	<input type="checkbox"/> no
High Blood Pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no		Unexplained fevers/chills/sweats	<input type="checkbox"/> yes	<input type="checkbox"/> no
Hypoglycemia	<input type="checkbox"/> yes	<input type="checkbox"/> no		Unexplained illness	<input type="checkbox"/> yes	<input type="checkbox"/> no
Kidney Problems	<input type="checkbox"/> yes	<input type="checkbox"/> no		Unexplained nausea/vomiting	<input type="checkbox"/> yes	<input type="checkbox"/> no
Liver/Gallbladder Problems	<input type="checkbox"/> yes	<input type="checkbox"/> no		Unexplained weakness	<input type="checkbox"/> yes	<input type="checkbox"/> no
Metal Implants	<input type="checkbox"/> yes	<input type="checkbox"/> no		Unexplained weight loss/gain	<input type="checkbox"/> yes	<input type="checkbox"/> no

If yes to any of the above, please briefly explain and provide approximate date \_\_\_\_\_

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Do you have any other medical issues or previous medical conditions not mentioned above?

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Please list any current medications \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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## OFFICE POLICIES

Patient's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name (printed): \_\_\_\_\_

### Consent to Treatment

\_\_\_\_\_ (initial) I give my consent for Nicole Haas, PT, DPT, OCS to evaluate and treat my condition within the scope of practice defined by the American Physical Therapy Association, and to provide physical therapy care and treatment considered necessary and proper in evaluating and treating my physical condition. I understand that this consent is intended as a waiver of liability for such treatment excepting acts of negligence.

### Notice of Privacy & Electronic Communication Policies

\_\_\_\_\_ (initial) I understand that Nicole Haas, PT, DPT, OCS will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I also understand that electronic communication is the primary method for scheduling and exchange of my personal health information for the purposes of carrying out treatment, and acknowledge that I am aware that email is not considered a secure method of communication, and agree to the risks.

### Payment for Services

\_\_\_\_\_ (initial) I understand that PT Boulder | Haas Physical Therapy & Wellness is a fee-for-service clinic. This means that payment is due at the time services are rendered and your insurance company (if applicable) is not billed. Upon request, receipts with diagnosis and treatment codes can be provided which may be submitted to your insurance company for reimbursement under "out of network benefits." Payment is accepted with cash, personal checks, and credit cards via Square Processing, and is separate from CrossFit Sanitas.

### Cancellation/No Show Policy

\_\_\_\_\_ (initial) I understand that there is a 24 hour cancellation policy and that I will be charged in full for all appointments that are not cancelled 24 hours in advance of the scheduled appointment time. I also understand that I will be charged in full if I fail to show up for my scheduled appointment as well.

### Notice of Privacy Practices for Protected Health Information. Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Nicole Haas, PT, DPT, OCS is required to provide you with the option of receiving a copy of this notice. You are able to receive this notice either electronically or on paper.

\_\_\_\_\_ (initial) I am aware that this notice is available to me online at PTBoulder.com, and I choose to view such notice electronically or I have requested to receive a paper copy of the above. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.