PATIENT DEMOGRAPHICS

Name* _____ Date of Birth* _____ Age* _____

Parents or Guardian(if minor) _____ Home Number _____

Cell Number _____

Address* _____

Work Number _____

City* _____ State* _____

Zip* _____

Email* _____

EMERGENCY CONTACT

Name* _____ Phone Number* _____

Relationship* _____

INSURANCE

Name of Insurance Carrier* _____ Group number* _____

Policy Number* _____

If Patient and Policy Holder are the same please check ☐

Policy Holder Name _____ Date of Birth _____

Auto Insurance and Personal Liability (if applicable) ☐

Do you have a MD prescription ○ Yes ○ No Referring MD _____

How did you hear about us? _____

HISTORY OF PRESENT CONDITIONS

When did your symptoms begin? _____

Are your symptoms: ○ Constant ○ Intermittent ○ Improving ○ Worsening ○ Unchanging ○ Activity Dependent

Did you have surgery ○ Yes ○ No If Yes, Date _____ Type of Surgery _____

How did your injury/issue start? _____

What is your primary concern? _____

Have your received treatment for this before? ○ Yes ○ No Did it get better? ○ Yes ○ No

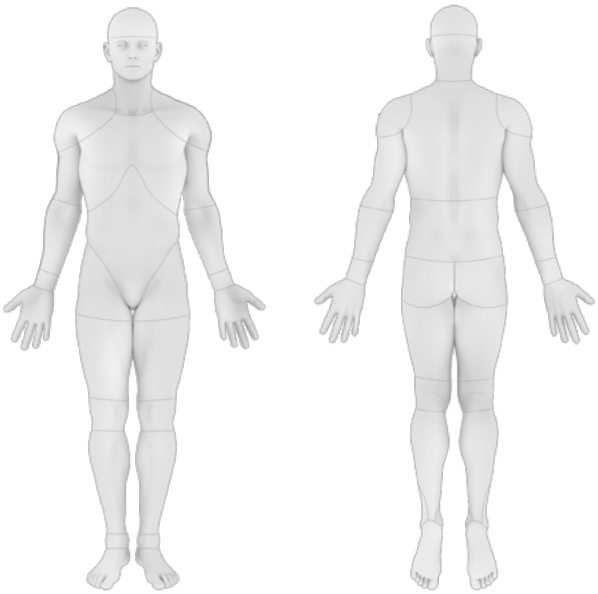
Where? _____ When? _____

Do your symptoms interrupt your sleep? ○ Yes ○ No

Does coughing, sneezing or taking a deep breath change your symptoms? ○ Yes ○ No

When is your pain the worst? ○ Morning ○ Night ○ At Rest ○ During Activity ○ After Activity

PAIN DRAWING



PAIN RATING - please rate your pain in the scale below, circle the number that best represents your pain:

	Feel Great	Annoying	Nagging Pain	Hurts even more	Intense Horrible	Unbearable
Worst pain in the past 48 hours:	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Current intensity of pain:	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Best pain in the past 48 hours:	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

What makes your pain worse? _____

What makes your pain better? _____

PATIENT MEDICAL SCREENING QUESTIONNAIRE

Do you smoke? ○ Yes ○ No Do you have a pacemaker? ○ Yes ○ No

Do you use a ○ Cane ○ Walker ○ Wheelchair ○ Other _____

Women only: Are you currently pregnant or think you may be pregnant: ○ Yes ○ No

Past Medical History: Please check all that apply, if none apply check here ☐

☐ Alzheimer s	☐ Diabetes Type 2	☐ Immunosuppression	☐ Rheumatoid Arthritis
☐ Cardiovascular Disease	☐ Fibromylagia	☐ Lupus	☐ Traumatic Brain Injury
☐ Cauda Equina Syndrome	☐ Fracture or Suspected Fracture	☐ Muscular Dystrophy	☐ Asthma
☐ Cerebral Vascular Accident	☐ High Blood Pressure	☐ Obesity	
☐ Current Infection	☐ History of Cancer	☐ Osteoarthritis	
☐ Diabetes Type I	☐ Huntington s	☐ Parkinson s	

☐ Other _____

Has anyone in your family ever been diagnosed with any of the above? If so, please list below:

Please list any surgeries or other conditions, with dates, for which you have been hospitalized:

Please list any previous injuries and date:

Please list any diagnostic tests (x-rays, MRI, EMG, CT etc.) and dates performed:

Have you RECENTLY noted any of the following? Please check all that apply, if none apply check ☐

☐ Fatigue	☐ Sudden Weight Loss/Gain	☐ Shortness of Breath	☐ Fever/Chills
☐ Headaches	☐ Difficulty Walking	☐ Loss of Balance	☐ Nausea/Vomiting
☐ Falls	☐ Difficulty Swallowing	☐ Numbness/Tingling	☐ Constipation/Diarrhea
☐ Dizziness	☐ Lightheadedness	☐ Muscle Weakness	☐ Heartburn/Indigestion
☐ Changes in Bladder/Bowel Function		☐ Depression	

If you are currently not taking any medications please check here: ☐

Please list current medications, over the counter medication, vitamins, and supplements (include dosage and purpose):

What are your goals or things you want to get back to doing?

AUTHORIZATION TO TREAT

I voluntarily consent to Physical Therapy consisting of evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatments being provided. I authorize KINĒCIO to provide such treatments. My healthcare provider, Insurer, or plan may require a Physician referral or prior authorization. I may be obligated for partial or full payment for therapy services rendered.

PAYMENT AUTHORIZATION

I understand that all balances designated as the patient s responsibility such as co-insurance, co-payments and deductibles are due and payable tdKINĒCIO. As part of working with my insurance carrier, I understand and acknowledge that I am financially responsible for services received from KINĒCIO and personally guarantee payment in the event that services are not paid for by my insurance company. Further, I guarantee payment with my credit card and authorize KINĒCIO to charge my credit card for any unpaid account balance that remains 60 days after charge has been incurred, including co-pays, deductibles, and a service charge of $50 for each un-kept appointment.

INSURANCE BENEFITS ASSIGNMENT

I authorized that the payment of my insurance benefits be made directly to KINĒCIO for all services delivered; if I am paid directly I will promptly pay KINĒCIO all monies paid to me.

HIPPA PRIVACY POLICY

By signing below I indicate that I have been given the Notice of Privacy Practices for KINĒCIO Physical Therapy. I understand that outside of purposes of treatment, for payment, for certain healthcare operations or as permitted or by law I must give my written authorization to KINĒCIO to release any of my protected healthcare information.

CANCEL/NO SHOW POLICY

We ask that if you are unable to keep your appointment, that a 24-hour notice is given. We understand emergency situations may arise and just ask that you call us as soon as possible. We will apply a service charge of $50 for each un-kept appointment. Following 2 consecutive No Shows, all future appointments will need to be prepaid by credit card, check or cash at the time of scheduling.

RECORD RELEASE

I am aware that KINĒCIO may release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, ORC or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care.

REMINDER EMAIL/TEXTS

As a service to our clients, we provide reminder emails and texts regarding your appointments. By providing your phone number and email you consent to these correspondences.

☐ I HAVE READ AND UNDERSTOOD AND AGREE TO UPHOLD THE POLICIES OF KINĒCIO PHYSICAL THERAPY

Medicare patients only: Are you currently or in the last 30 days received Home Health Care? ○ Yes ○ No

If yes, you must provide discharge papers at first appointment

Patient's Initials* (parent/guardian if minor) _____ Guardian Relationship* _____

Full Name* _____ Date _____