

**PATIENT DEMOGRAPHICS**

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

Parents or Guardian(if minor) \_\_\_\_\_ Gender\*  Male  Female

Address\* \_\_\_\_\_ Home Number \_\_\_\_\_

City\* \_\_\_\_\_ State\* \_\_\_\_\_ Cell Number \_\_\_\_\_

Zip\* \_\_\_\_\_ Work Number \_\_\_\_\_

Email\* \_\_\_\_\_

**EMERGENCY CONTACT**

Name\* \_\_\_\_\_ Phone Number\* \_\_\_\_\_

Relationship\* \_\_\_\_\_

**INSURANCE**

Name of Insurance \_\_\_\_\_ Group number\* \_\_\_\_\_  
Carrier\* \_\_\_\_\_

Policy Number\* \_\_\_\_\_

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 you received treatment for this before?  Yes  No

Did it get better?  Yes  No

Where? \_\_\_\_\_

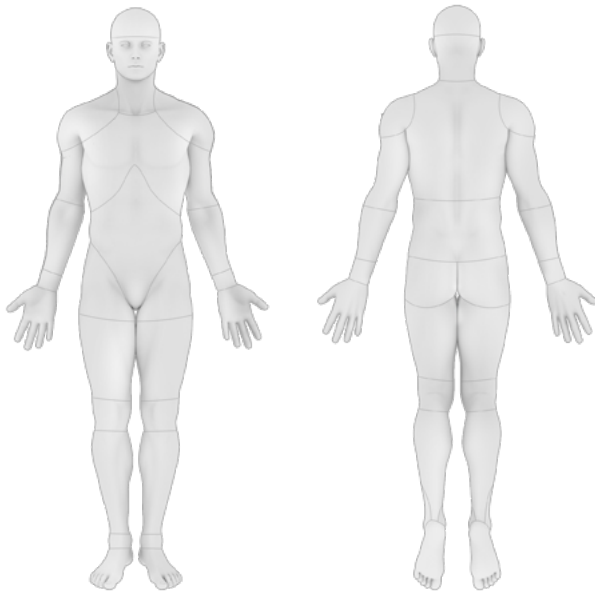
When? \_\_\_\_\_

Do your symptoms interrupt your sleep?  Yes  No

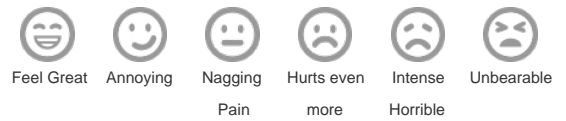
Does coughing, sneezing or taking a deep breath change your symptoms?  Yes  No

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:



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

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Alzheimer s                | <input type="checkbox"/> Diabetes Type 2                | <input type="checkbox"/> Immunosuppression  | <input type="checkbox"/> Rheumatoid Arthritis   |
| <input type="checkbox"/> Cardiovascular Disease     | <input type="checkbox"/> Fibromyalgia                   | <input type="checkbox"/> Lupus              | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Cauda Equina Syndrome      | <input type="checkbox"/> Fracture or Suspected Fracture | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Cerebral Vascular Accident | <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Obesity            |   |
| <input type="checkbox"/> Current Infection          | <input type="checkbox"/> History of Cancer              | <input type="checkbox"/> Osteoarthritis     |   |
| <input type="checkbox"/> Diabetes Type I            | <input type="checkbox"/> Huntington s                   | <input type="checkbox"/> Parkinson s        |   |
| <input type="checkbox"/> 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

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Fatigue                           | <input type="checkbox"/> Sudden Weight Loss/Gain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fever/Chills          |
| <input type="checkbox"/> Headaches                         | <input type="checkbox"/> Difficulty Walking      | <input type="checkbox"/> Loss of Balance     | <input type="checkbox"/> Nausea/Vomiting       |
| <input type="checkbox"/> Falls                             | <input type="checkbox"/> Difficulty Swallowing   | <input type="checkbox"/> Numbness/Tingling   | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Dizziness                         | <input type="checkbox"/> Lightheadedness         | <input type="checkbox"/> Muscle Weakness     | <input type="checkbox"/> Heartburn/Indigestion |
| <input type="checkbox"/> Changes in Bladder/Bowel Function |  | <input type="checkbox"/> 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 to KINĒCIO. 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\* \_\_\_\_\_