CORNERSTONE PHYSICAL THERAPY

www.TheCornerstonePT.com

5517 S Hulen St,
Fort Worth, TX 76132
P: (817) 439-6200
F: (817) 439-6211
Email: info@thecornerstonept.com

New Patient Intake Form

Patient Informations

Last Name:_____ First Name: _____ Sex: M / F

Street Address/Apt# :_____City:_____State: _____ Zip code:_____

Mobile number :_____ Home Phone: _____

Date of Birth (MM/DD/YYYY): _____ Social Security: _____

Email Address:_____ Employer:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ other

Emergency Contact

Last Name:_____ First Name: _____

Relationship :_____ Phone number : _____

Doctor Information ****Please provide Doctor who referred you to therapy below**:

Last Name:_____First Name: _____ Phone: _____

****Please provide your Family/Primary care Doctor below (if different than above)**

Last Name:_____First Name: _____ Phone: _____

Primary Insurance Company

Policy Holder is: ____ Self ____ Spouse ____ Parent

Insurance Name:_____

Patient ID/Policy # : _____ Group Number: _____

Secondary Insurance Company

Policy Holder is: _____ Self _____ Spouse _____ Parent

Insurance Name:_____

Patient ID/Policy # : _____ Group Number: _____

Insurance Policy Holder:

Last Name:_____ First Name: _____ Sex: **M / F**

Date of Birth:_____ Phone Number: _____

For Medicare Patients Only:

Are you currently receiving home care services? **Y/N**. If yes, expected date of completion? _____

Patient Signature:_____ Date: _____

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Medical History

Patient Name:_____Age:_____ Height: _____Weight:_____

Please check below all that apply:

- ☐ History of Diabetes
- ☐ Hearing Difficulty
- ☐ Hypertension (high blood pressure)
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Smoking
- ☐ Chest Pain/Angina
- ☐ Light-Headedness / Dizziness / Fainting
- ☐ Hypotension (low blood pressure)
- ☐ Night Coughing
- ☐ Cancer / Tumors / Growths
  *Radiation / Chemotherapy Treatment
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Disease
- ☐ Stroke

In the past 3 months have you experienced:

- ☐ Changes or difficulty with Bowel
- ☐ Changes or difficulty with Bladder
- ☐ Night sweats
- ☐ Fever

- ☐ Multiple Sclerosis
- ☐ Brain Injury
- ☐ Spinal Cord Injury
- ☐ Skin Sensitivities
  Latex / Adhesives / Temperature
- ☐ Pacemaker / Defibrillator
- ☐ Bleeding / Bruising (recent history)
- ☐ Hypoglycemia
- ☐ Active seizure disorder
- ☐ Dementia / Alzheimer's
- ☐ Kidney Disease
- ☐ Asthma
  - ☐ Always have inhaler with you
- ☐ Lung Disease / Emphysema / COPD
  - ☐ Oxygen use
- ☐ Are you pregnant
- ☐ Depression

Fractures
DATE:_____ AREA:_____
DATE:_____ AREA:_____

- ☐ Fallen last year
  * How many times? _____
  * Injury due to fall? _____
  * Are you afraid of falling? _____

1. Why are you here?_____
2. When (date) did your problem/injury begin? _____
3. Have you been treated for this before? Yes No

   When? _____
   How? _____
4. Please List Surgery(s) within the last 3 months - Include Dates:

   _____
5. What are your personal Goals / Outcomes you hope to achieve from Therapy

   _____

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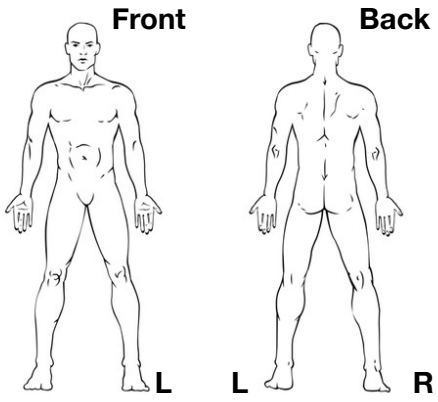
Patient Signature: _____ Therapist Signature: _____ Date:_____

Medical Screening Form

Patient Name:_____ Date: _____

I have Pain: ☐ Yes or ☐ No

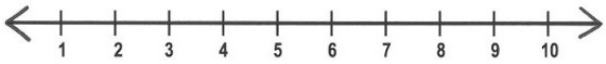
Please use the diagram below to indicate where you feel symptoms right now.



Use the Key below to indicate the different type of symptoms

KEY:
Pins and Needles = 0000000 **Stabbing** = /////////

Please mark your **best**(**B**), **current** (**C**) and **worst** (**W**) pain or symptom on the following line:
(**0**= none —>**10** = worst imaginable. Indicate level for each with **B**,**C**, and **W**)



1. What makes your pain or symptoms worse? _____
2. What makes your pain or symptoms better? _____
3. Are your symptoms (check one) ☐ Getting worse ☐ The same ☐ Improving
4. How are you able to sleep at night? (check one) ☐ Fine ☐ Moderate Difficulty ☐ Only with Medication
5. Do you have Pain at night? ☐ Yes ☐ No

PATIENT SPECIFIC FUNCTION SCALE:
(First Time Use For This Case) Identify up to three (3) important activities that you are unable to do or are having difficulty with as a result of your medical condition. Using the scale below indicate your ability to perform these activities today. *(**0** = unable to perform —> **10** = as able as pre-injury)*

1.	Activity _____	0	1	2	3	4	5	6	7	8	9	10
2.	Activity _____	0	1	2	3	4	5	6	7	8	9	10
3.	Activity _____	0	1	2	3	4	5	6	7	8	9	10

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Patient Consent Form

CONSENT FOR TREATMENT: I consent to rehabilitation and related services at this facility 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.

Initial: _____ Date: _____

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.

Initial: _____ Date: _____

LIABILITY: I know and agree that this facility is not responsible for loss or damage to personal valuables.

Initial: _____ Date: _____

WAIVER AND RELEASE: I hereby release, discharge and acquit Cornerstone 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.

Initial: _____ Date: _____

AUTHORIZATION OF PAYMENT: I do hereby consent to the release of protected health information as needed to process my medical claims. I assign all benefit payments for services provided by Cornerstone Physical therapy to this facility. I understand that I am responsible for copayments, coinsurance, deductibles and other services not covered by my medical insurance company.

Initial: _____ Date: _____

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.

Initial: _____ Date: _____

Patient Signature: _____ Date: _____

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CANCELLATION AND NO-SHOW POLICY

We strive to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient in order to minimize your waiting and assure continuity of your treatment.

Your consistent attendance of the planned treatment regimen is paramount to your full recovery. Not attending your scheduled therapy appointments may have adverse effects on your health with potentially long-term negative consequences.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Cancellations of your appointments should be called during regular business hours but can be left on the voicemail during weekends and holidays or other times of closure.

The details of the policy are:

- *If you are more than 20 minutes late for your appointment and fail to notify us in advance, treatment may be rescheduled.*
- *We ask that all cancellations are called in at least 24 HOURS IN ADVANCE.*
- *Failure to show up for an appointment ("NO SHOW") 3 consecutive times will result in the cancellation of all remaining scheduled appointments.*
- *All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.*

The staff appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities.

Patient Signature: _____ Date: _____