

Personal Injury Intake Form

Patient Information

Date: _____ Date of Birth: ___/___/___
Name: _____ Social Security: ___-___-___
Address: _____
Street City State Zip
Email Address: _____
Home Phone: _____ Cell Phone: _____
Gender: _____ Height: _____" Weight: _____ lbs
Marital Status: _____ Number of Children: _____
Employer: _____ Occupation: _____ Work Phone: _____
Employer Address: _____
Street City State Zip
Attorney: _____ Phone: _____
Emergency Contact: _____ Relation: _____
Emergency Contact Phone Number: _____
If under 18 years, name of Parent or Guardian: _____
PCP Name: _____ Phone: _____
How did you hear about our office ? Website Gym member Walk in Yellow
pages Friend/Former patient _____ Doctor _____
 Other _____

Accident Information

Date: _____ Time: _____ AM PM Was it reported? YES NO
Town accident occurred in: _____ Street: _____
Please explain in detail how the accident occurred: _____

Please list symptoms felt immediately after the accident: _____

Were you in a work vehicle at the time of the accident? YES NO
Were you the DRIVER FRONT SEAT PASSENGER BACK SEAT PASSENGER?
Were you wearing a seat belt? SHOULDER HARNESS LAP HARNESS
Where were you taken after the accident? _____
If hospital, how were you taken? AMBULANCE PRIVATE VEHICLE OTHER
Were X-Rays done? YES NO An MRI? YES NO CAT scan? YES NO
Have you seen any other doctor(s) since the accident? YES Name _____ NO
Have you missed any work since the accident? YES NO Date(s) _____
Did you ever experience similar symptoms prior to the accident? YES NO
Has your condition IMPROVED WORSENER or STAYED SAME since the accident?
Please share any other information that might be important to your diagnosis and
treatment: _____

Patient Signature (Parent/Guardian or Minor): _____ **Date:** _____



Acknowledgement of Office Policies

The following are Bay State Physical Therapy and MCR Chiropractic's policies governing appointment scheduling, payment terms, and information releases. **Please read carefully** and be sure to ask questions you might have before signing the document.

Appointment Scheduling: We at Bay State Physical Therapy and MCR Chiropractic are glad to accept insurance assignment on your behalf in handling your personal injury or worker's compensation claim. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. We require a 24 hour cancellation notice for all appointments. If you miss three (3) or more appointments without 24 hour notice, you may be dismissed from care and your file may be closed.

Consent for Treatment: I, the undersigned, give Bay State Physical Therapy and/or MCR Chiropractic my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, condition may worsen on rare occasions. I further understand that no guarantee or promise has been made to me concerning the results of treatment. I further understand that the gym and/or pool areas are common areas accessed by patients, gym members and guests and as a result there may be incidental contact with personal health information.

Assignment of Payment: I hereby authorize my insurance company and/or my attorney to pay direct to Bay State Physical Therapy and/or MCR Chiropractic any monies due on my account for professional services rendered.

Acknowledgment and Understanding: It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Private Health Insurance: I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments).

Authorization to Release Information: I have read and fully understand Bay State Physical Therapy and/or MCR Chiropractic's Notice of Information Practices. I understand that Bay State Physical Therapy and/or MCR Chiropractic 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 payments, understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Bay State Physical Therapy and/or MCR Chiropractic will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

Patient Requests for Records: I instruct the release of all medical, hospital, or surgical records pertinent to my case, including but not limited to exams, special test, x-rays, or lab results to this office.

Ownership: I understand that MCR Chiropractic, Bay State Physical Therapy, Optimal Weight Loss, and Massage Works! Are all owned and operated by the same entity. I understand I have the option to seek any/all of the same services these clinics provide elsewhere.

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature: _____ Date: _____
Name (Please Print): _____ DOB: _____
Witness Signature: _____ Date: _____
Name (Please Print): _____

Designate Individuals Authorization Form

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Please give the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name

DOB: _____

Patient Signature

Date: _____

Medical History Form

Name: _____ DOB: ___/___/___ Today's Date: ___/___/___

Occupation: _____ Gender: _____ PCP: _____

Referring Physician (MD): _____ Next appointment w/ referring MD: ___/___/___

Please answer the following questions:

What injury or condition brings you here today? _____

When did you first notice your condition (date of onset)? _____

How did this injury occur? _____

Is your condition due to a motor vehicle accident? Yes No If yes, date of accident? _____

Have you had any falls in the past 12 months? Yes No If yes, how many times? _____

Did the fall(s) result in injury? Yes No If yes, please describe: _____

Please describe above: _____

Are you seeing (or have you been seen by) any other specialists for your current condition (e.g.: doctor, psychologist, chiropractor, physical therapist, etc.)? Please list: _____

Have you been treated by another physical therapist/chiropractor in the past for this or any other condition?

Yes No

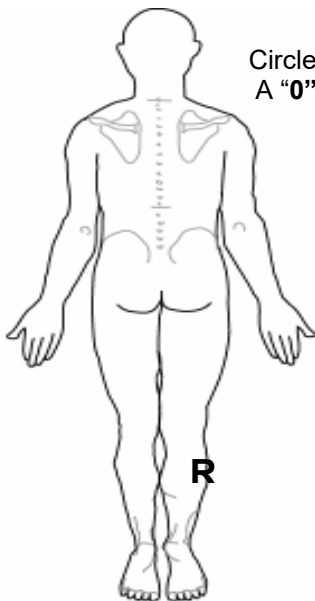
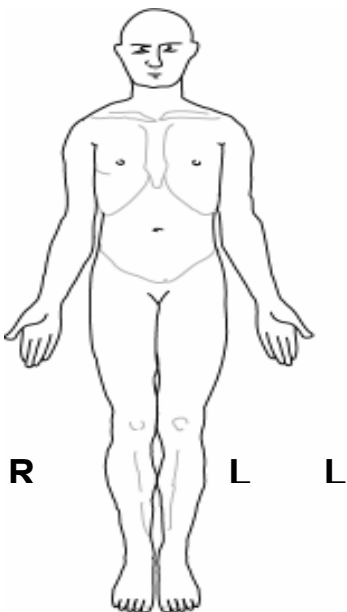
If Yes, by whom/when? _____

What tests have you had for this condition? X-ray MRI CT scan Other: _____

Please mark where you have symptoms on the picture below.

Sharp Pain: ////////////// Achy Pain: ^^^^^^ Burning Pain: XXXXXX Numbness: 0000

Circle the number corresponding with the intensity of your symptoms.
A "0" = No Pain whereas a "10" = most severe pain imaginable.



Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Since this condition began your symptoms have: decreased not changed increased



Your symptoms are worse in the: morning afternoon night same all day

What are your goals for treatment? _____

Please list past surgeries/conditions/hospitalizations:

_____/_____/_____
_____/_____/_____

Please list all medications, dosage, frequency and route (or you may attach a separate list):

Name: _____ Dosage: _____ Frequency: _____ Route: _____

Name: _____ Dosage: _____ Frequency: _____ Route: _____

Name: _____ Dosage: _____ Frequency: _____ Route: _____

Have you ever been diagnosed and/or treated for any of the following conditions (circle all that apply):

CONSTITUTIONAL

- Weight Loss
- Fatigue
- Fever

EYES

- Glasses/Contacts
- Eye Pain
- Double Vision

CATARACTS

CARDIOVASCULAR

- Murmur
- Chest Pain
- Palpitations
- Fainting/Spells
- Short of Breath
- Difficulty Lying Flat
- Swelling in Ankles
- Pacemaker/Defibrillator

ENDOCRINE

- Loss of Hair
- Heat Intolerance
- Cold Intolerance
- Diabetes Type I or II

ALLERGIC

- Hives/Eczema
- Hay Fever

PSYCHIATRIC

- Anxiety
- Depression
- Mood Swings
- Difficulty Sleeping

RESPIRATORY

- Cough
- Coughing Blood
- Wheezing
- Chills
- GASTROINTEST**
- Heartburn/Reflux
- Nausea/Vomiting
- Constipation
- Change Bowel Mvts
- Diarrhea
- Jaundice
- Abdominal Pain
- Black/Bloody Bowel Mvts

GENITOURINARY

- Burning/Frequency
- Nighttime
- Blood in Urine
- Erectile Dysfunction
- Bladder Leakage
- Abnormal Leakage

HEMATOLOGY/LYMPH

- Bruise Easily
- Gums Bleed Easily
- Enlarged Glands

MUSCLE/BONE

- Joint Pain/Swelling
- Stiffness
- Muscle Pain
- Bone Pain

SKIN

- Rashes/Sores
- Lesions
- Itching/Burning

NEUROLOGICAL

- Loss of Strength
- Numbness
- Headaches
- Tremors

MEMORY LOSS

CANCER

Date of diagnosis: _____
Location: _____
Status: _____

FEMALES ONLY

Age Onset of Periods _____
Periods Regular? Yes/No _____
Age Onset of Menopause _____
Number of Pregnancies _____

Please list any allergies that you have (For example: medications, latex, food, bee stings): _____

Is there any additional information? _____

The above information is true to the best of my knowledge.

Signature: _____ DOB: ____/____/____ Date: ____/____/____



Acknowledgement of Privacy Policy (HIPAA)

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Bay State Physical Therapy and/or MCR Chiropractic's *Notice of Privacy Practices for Protected Health Information*.

Patient Name Printed Date

Patient Signature or Authorized Representative Date of Birth

Authorized Representative Name Printed and Relation to Patient



Cancellation Policy

At Bay State Physical Therapy and/or MCR Chiropractic, we are committed to giving the highest quality of care. Part of that includes our recognition of your busy schedule and your desire to achieve positive results in the shortest time possible. We pride ourselves on starting your treatment at your scheduled time and giving you appointments that work with your busy schedule. We respect your time and ask for your cooperation by maintaining your appointments in order to maximize your rehabilitation potential.

If you are unable to make your appointment, we ask that you reschedule your appointment within the same week rather than canceling. If you need to cancel your appointment and cannot reschedule within the same week, we ask that you provide us with a minimum of 24-hour notice so that we may offer your appointment time to another patient awaiting treatment. If you miss three (3) or more appointments without 24-hour notice, you may be discharged from physical therapy and your physician will be notified.

If you do not provide at least 24-hour notice you will be assessed a \$50 fee for your missed physical therapy appointment(s) and \$35 for your missed chiropractic appointment(s).

Please note that this charge cannot be billed to insurance and must be paid on or before the next scheduled appointment. By signing below, you acknowledge that you have read and understand our cancellation policy.

Signature (Parent/Guardian of Minor): _____ Date: __/__/__



Consent to Treat a Minor

I, _____, authorize the physical therapists and/or doctors
(name and relationship to child under 18 years old)

of Bay State Physical Therapy and/or MCR Chiropractic to examine and subsequently provide

treatment for _____.
(name of child under 18 years old)

I realize that exam and treatment procedures may also be performed by assistants, but under the direction of the physical therapists and/or doctors of Bay State Physical Therapy and/or MCR Chiropractic.

Name (print): _____

Signature: _____ Date: _____