Carolina Strong
PHYSICAL THERAPY

Carolina Strong Physical Therapy
3960 Executive Park Blvd, Unit 5
Southport, NC 28461
Office 910-375-5748
Fax 910-375-5761

Patient Information

Last Name/Suffix		First Name		Middle Initial
Address:	City		State:	Zip Code:
Home Phone	Other Phone (Cell)		Email Address:	
Date of Birth	SSN	Sex: ☐ M ☐ F	Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown	

Employer Information

Employer Name:	Employment Status: ☐ None ☐ FT ☐ PT ☐ Self-Emp. ☐ Retired ☐ Student
Work Phone Number	Patient Occupation

Primary Insurance Carrier / Policy Holder Information

Primary Insurance:		Insurance Identification Number:	
Policy Holder Name:		Sex: ☐ M ☐ F	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Other
Policy Holder Date of Birth:	Policy Holder SSN	Policy Holder Address:	
Policy Holder Home Phone:		Employer / Employer Address:	

Secondary Insurance Carrier / Policy Holder Information

Secondary Insurance:		Insurance Identification Number:	
Policy Holder Name:		Sex: ☐ M ☐ F	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Other
Policy Holder Date of Birth:	Policy Holder SSN	Policy Holder Address:	
Policy Holder Home Phone:		Employer / Employer Address:	

Physician Information

Name of Referring Physician:	Name of Primary Care Physician:

Emergency Contact Information

Contact Name:	Phone #:	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other

Additional Questions

Date of Injury / Onset Date	Accident Related: ☐ Yes ☐ No ☐ Auto-State? ______ ☐ PI	Work Related: ☐ Yes ☐ No	Diagnosis/Body Part
Post Surgical: ☐ Yes / ☐ No / ☐ Unknown Surgery Date (if applicable): ____________		Surgery Description: ______________________________	
Have you had any prior Therapy this year? ☐ Yes ☐ No (PT/OT/SP or Chiropractic)		How did you hear about us?	

I understand that if any changes are made to my personal or insurance information while being treated it is my responsibility to inform the facility of said changes in a timely manner.

Appointment Date:	Time:	Therapist:

Intake Completed By: ______________________ Date:__________	**I, acknowledge that the above information is correct** **Patient/Guardian**__________ **Date:**

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Physical Therapy Patient Intake Form

Name:	Date:
Date of Birth:	Age:

1. What is the main reason for your visit and goals you wish to achieve?

___

List hobbies and activities you enjoy___

___

2. Have you had similar problems which required treatment? Yes No

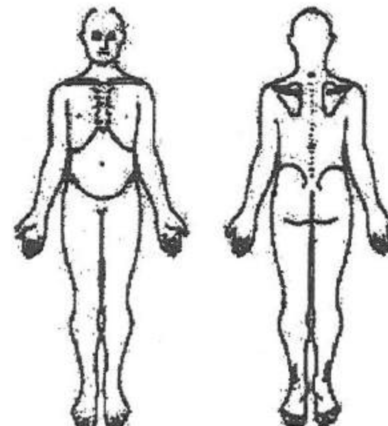
3. Have you had previous Physical Therapy? Yes No

4. When did your symptoms begin?___

5. What are you having a difficult time doing as a result of your primary problem?

___

6. On the diagram, please mark the areas of your pain:



7. Types of pain you feel (circle):

Stabbing sharp soreness pulsing catching tearing

Aching Pinching Throbbing numbness tingling burning

Pins and needles bruised electrical/shock other: ___

8. Is your pain (circle):
Constant Intermittent Occasional Rare improving worsening unchanging

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Physical Therapy Patient Intake Form

9. On a scale from zero to ten with ten being the worst pain imaginable, how would you rate your pain?

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild, annoying pain		Nagging, uncomfortable, troublesome pain		Distressing, miserable pain		Intense, dreadful, horrible pain		Worst possible, unbearable, excruciating pain

Best________ Worst________ Current________

10. When are your symptoms the worst?
_____ Morning _____ Evening _____ Night _____ Varies
_____ Does not apply _____ Other

11. Do your symptoms awaken you during the night? Yes No

13. Do you have either bowel or bladder incontinence? Yes No

14. Have you had any of the following diagnostic tests? : ____x-ray ____MRI
______CT scan _____Myelogram ______EMG _____DXA/bone density test
______bone scan _____other

15. Please indicate any surgeries or hospitalizations in past 5 years ________________

____

16. Please list current medications and dosages (we can copy a list if you carry one)

____

____

____

17. Do you have any allergeries? Yes No
If yes, please list your allergeries ________________________________

____

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Medical History

Cardiac
___Pacemaker
___High Blood Pressure
___Fast Heart Rate
___Heart Attack
___Heart Surgery
___High Cholesterol
___Chest Pain

General Health
___Cancer What kind:_______
___Kidney Disease
___Fever
___Pain at night
___Fatigue/tiredness
___Unexplained weight loss or gain

Ears/eyes
___Hearing loss
___vision loss
___double vision

Respiratory
___Shortness of breath
___Asthma
___coughing
___spitting up blood

Endocrine
___Diabetes
___Thyroid problem
___Cold intolerance

Gastrointestinal
___Nausea/vomiting
___Frequent diarrhea
___Rectal Bleeding
___Abdominal Pain
___Peptic ulcer

Hematology/lymphatic
___Slow to heal after cuts
___Bleeding/bruising tendency
___Anemia
___Hepatitis

Musculoskeletal
___Joint pain
___Muscle pain
___Muscle weakness
___Joint stiffness/cramping
___Gout
___Osteoarthritis
___Recent fractures/ broken bones
___Metal implants
___Recent falls
___Rheumatoid Arthritis
___Osteoporosis

Genitourinary
___Incontinence
___Frequent urination
___Blood in urine
___Burning/painful urination
___Female menopause
___Female irregular period
___Sexually transmitted disease
___Pregnancy
___Sexual difficulty

Neurological
___Stroke
___Frequent headaches
___Lightheadedness/dizziness
___Seizures
___Numbness/tingling
___Tremor
___Head injury
___Blackout/loss of consciousness

Psychiatic
___Nervousness
___Depression
___Insomnia

Skin
___Rash
___Change in skin color
___Varicose veins

General Consent

- I consent to medical treatment and care at this facility.
- I agree this facility is not responsible for any loss or damage to my property.
- I am aware that healthcare is not an exact science and no guarantees have been made.

I understand and agree with the above information.

Patient/Responsible Person Signature_____________ Date _____ Time______

Financial Responsibility

- I agree to pay for all medical services provided
- I understand that I may need to call my insurance company to see if they will approve and pay for the medical care
- Please bill my health insurance plan as a service to me. I am aware that this does not mean they will agree to pay for any services. I agree to pay whatever amount is not covered.
- I assign all my rights and claim for payment under any health insurance plan to Carolina Strong Physical Therapy
- I appoint Carolina Strong Physical Therapy, the other treating providers and/or their agents as my "authorized representative" to act for me in getting payment for services provided
- I give permission to be called on any of the telephone numbers I have given. Calls made be made by businesses helping my provider collect money that I owe.

I understand and agree with the above information.

Patient/Responsible Person Signature:_______________ Date:______ Time:_______

Acknowledgement of Receipt of Notice of Privacy Practices

HIPAA- Notice of Privacy Practices

- I have been provided with a copy of Carolina Strong Physical Therapy's Joint Notice of Privacy Practices.
- I know that the notice may be changed at any time.

I understand and agree with the above information

Patient/Responsible Person Signature:________________ Date:______ Time:_______