



Patient Intake Forms

Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Preferred: Home Cell

Height: _____ Weight: _____ Sex: _____

E-Mail: _____ Would you like to receive updates about our clinic?: Y N

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Leisure activities, including exercise routines: _____

Occupation: _____ Work demands/duties: _____

Health Insurance: _____ Subscriber ID: _____

Is this related to a Car Accident: Yes No Work Injury: Yes No Date of Injury: _____

Auto/Workers Comp Insurance: _____ Claim #: _____

Adjustor Name: _____ Phone Number: _____

Attorney Name: _____ Phone Number: _____

Are you on a work restriction from your doctor? Yes No Are you latex sensitive? Yes No

Do you smoke? Yes No If yes, how many packs/day? _____ Do you have a pacemaker? Yes No

Do you drink caffeinated beverages? Yes No If so, how many cups/day? _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

If so, do you have any complications with your pregnancy? Yes No

Have you had complications in the past? Yes No

Current symptoms present during or prior to pregnancy? Yes No

If yes, please explain _____

ALLERGIES: List any substances you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- | | | |
|---|--|--|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> constipation |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> fainting |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough |



- falls
- trauma
- changes in bowel or bladder function
- motor vehicle accident
- headaches
- resting/night pain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> lung problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> chest pain/angina | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> other arthritic condition | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke | <input type="checkbox"/> bladder/urinary tract infection | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> anemia | <input type="checkbox"/> kidney problem/infection | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> infection (i.e bone, joint, urinary tract) | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> chemical dependency (i.e., drug, alcohol) | <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> high cholesterol | | |

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots |

During the past month have you been feeling down, depressed, or hopeless? Yes No

During the past month have you been bothered by having little interest or pleasure in doing things? Yes No

Is this something with which you would like help? Yes Yes, but not today No

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

Have you ever taken steroid medications for any medical conditions? Yes No

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? Yes No

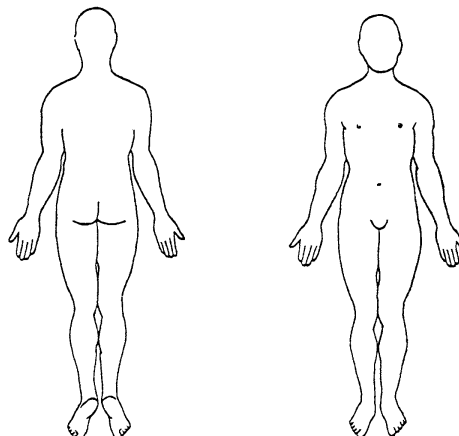
Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling





My symptoms currently: Come and go Are Constant Are constant, but change with activity

What date (roughly) did your present symptoms (pain, soreness, weakness, numbness, etc.) start? _____

What do you think caused your symptoms? _____

My symptoms are currently: Getting Better Getting Worse Staying about the same

I should not do physical activities that might make my pain worse: Disagree Unsure Agree

Treatment received so far for this problem (chiropractic, injections, etc) _____

How did you respond to this treatment? _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: Yes No When _____ Treatment rec'd _____

How long did it take for you to feel better? _____

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms the best? Morning Afternoon Evening Night After exercise

Using the 0 to 10 the scale, with 0 being “no soreness/pain” and 10 being the “worst pain imaginable” please describe:

Your current level of soreness/pain while completing this survey: _____

The best your soreness/pain has been during the past 48 hours: _____

The worst your soreness/pain has been during the past 48 hours: _____

What are your goals for physical therapy? i.e what do you have trouble doing, or can't do right now because of your current problem? _____

Do you have any barriers to learning? If so please list. _____



CONSENT FOR TREATMENT

I acknowledge that I have been referred to Soleil Physical Therapy & Wellness (S.P.T) for physical therapy services and will be subjected to various therapeutic procedures. I understand that the prescribed treatments may take the form of moist heat, cold, ultrasound, electrical stimulation, traction, therapeutic exercise, soft tissue and joint mobilization, and other recognized procedures utilized by physical therapists. I hereby authorize my consent for Soleil Physical Therapy & Wellness and the physical therapists they employ to treat me as prescribed.

Signed: X _____ Date: _____

AUTHORIZATION FOR PAYMENT

I acknowledge that I am financially responsible to Soleil Physical Therapy and Wellness for any debts not covered by third party payers which are incurred during the period of time in which I am receiving treatment for my physical ailment as prescribed by my physician. I request that payment of authorized insurance benefits be made either to me or on my behalf for any services furnished me to Soleil Physical Therapy and Wellness. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits, or the benefits payable for related services. Furthermore, should my third-party payer not permit assignment of benefits, I understand that the payment for services rendered will come to my residence. I understand that it is my responsibility to sign the check over to Soleil Physical Therapy and Wellness and agree to do so promptly.

Signed: X _____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize and direct Soleil Physical Therapy and Wellness to release information concerning my physical condition to insurance companies and other third-party payers who are involved in processing claims for payment of treatments and administered by S.P.T. I also authorize the release of medical information concerning my physical condition to my employer, if I am being treated for a work related injury, and Soleil Physical Therapy and Wellness is on my employer's designated list of duly licensed practitioners of the healing arts. Medical information concerning my physical condition may also be released to my employer or other parties if Soleil Physical Therapy and Wellness is in receipt of my signed authorization from such other parties. I also authorize Soleil Physical Therapy and Wellness to obtain medical records from medical offices relating to my current treatment.

Signed: X _____ Date: _____



Manual Therapy Treatment Consent Form

As a patient of Soleil Physical Therapy, you may receive manual physical therapy treatment, including soft tissue mobilization, joint mobilization, and joint manipulation.

I, _____, as a patient of Soleil Physical Therapy understand that I may receive manual physical therapy to improve soft tissue, joint, and spine mobility. I understand I will receive a thorough evaluation from my physical therapist before any manual therapy is initiated.

I agree to the following:

- It is my responsibility to report any signs or symptoms which make you uncomfortable and/or include the following:

| | |
|--|--------------------------------------|
| Headache / neck pain | Difficulty with speech or swallowing |
| Dizziness / vertigo / light-headedness | Walking or balance difficulties |
| Loss of consciousness | Nausea / Vomiting |
| Visual disturbance | Numbness in face or body |
- I agree that in order to undertake some evaluation and treatment effectively, it may be necessary to remove clothing that may otherwise prevent observation and/or examination.
- I agree that it is my responsibility to inform my therapist should I experience any pain, discomfort, or symptoms during any procedures. I acknowledge that it is the responsibility of my therapist to stop the procedure immediately should I indicate pain, discomfort, or symptoms or request that the procedure should be stopped.
- I understand it is my responsibility to provide feedback throughout each manual therapy technique.
- I understand that I have the right, at any time, to withdraw from the procedure, or a part thereof, without prejudice.
- I understand that transient side effects of spinal manipulation are not uncommon. Transient side effects include headache, stiffness, local discomfort, radiating discomfort, paraesthesia (altered sensation), fatigue, dizziness, and nausea.

I have read the above and declare that I am willing and able to receive manual therapy. I understand that in the event of physical injury or illness resulting from these techniques that I should seek treatment from my own physician.

| | | |
|-------------------------------------|----------------------------------|------|
| | X | |
| Name of Patient or Guardian (Print) | Signature of Patient or Guardian | Date |

| | |
|------------------------------|------|
| | |
| Physical Therapist Signature | Date |



Assignment and Release

I certify that I, and/or my dependent(s), have health insurance coverage with

Name of Insurance Company

and assign directly to Soleil Physical Therapy and Wellness, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above physical therapy clinic may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

X _____

Signature of the Patient, Parent, Guardian, or Personal Representative

Printed Name

Date

Relationship to Patient



Authorization to Use or Disclose Protected Health Information

I hereby authorize _____ to use or disclose the following protected health information from the medical records of the patient listed below. I understand that the information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and if so, may not be subject to federal or state law protecting it confidentiality.

Patient name: _____ Date of Birth _____

Address: _____

Street City State ZIP

Information to be disclosed to: **Soleil Physical Therapy & Wellness, Inc.**
111 Washington St. Suite 101
Quincy, MA 02169

Disclose to the following information for treatment dates: _____ to _____

- | | | |
|---|-------------------------------------|--|
| <input type="checkbox"/> Complete Records | <input type="checkbox"/> Consult | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Discharged Summary | <input type="checkbox"/> X-Ray | <input type="checkbox"/> Emergency Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Other Specified: |
| <input type="checkbox"/> Outpatient Reports | <input type="checkbox"/> Pathology | _____ |

The above information is disclosed for the following purposes:

- Medical Care Legal Insurance Personal Other

I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

This authorization expires on _____

X _____
 Signature of Patient or Legal representative Date

 Printed name of Patient or Patient's Representative Date



Cancellation Policy

Our office requires 24 hours notice to cancel or reschedule an appointment.

This allows us to offer this appointment time to another patient who needs to be seen.

Your insurance does not pay for missed appointments, so when you cancel without adequate notice, it has a financial impact on our small business. Therefore cancellations and no shows may be subject to a \$25 cancellation fee*. This is common practice at most medical offices. We will do our best to reschedule your appointment to another time the same week.

If you need to cancel or reschedule your appointment please call us at 617-376-3232 at least 24 hours before your appointment. If you choose to receive reminders via text message, you can also respond to the text to cancel your appointment. To cancel or reschedule a Monday appointment, please notify us before 4PM on Saturday.

Signature: X _____

Date: _____

All of us at Soleil will do our best to accommodate your schedule. We also use an automated reminder system to help. If you would like to take advantage of this service please let us know the best method:

Voice Call Text Email: _____