PARRY PHYSICAL THERAPY GROUP
HURT LESS. LIVE MORE.

Patient Intake Information

PATIENT INFORMATION			
First Name:	Last Name:	MI:	Date: / /
Address:		City:	
State:	Zip:	Email Address:	
Birth Date: / /	Age:	☐ Male ☐ Female	S.S. # - -
Marital Status: M S W D		How many children?	
Home Phone: ( ) -	Cell Phone: ( ) -	Work phone: ( ) -	
Why did you choose our clinic? ☐ Dr. ______________ ☐ Insurance Plan ☐ Family/Friend ________________			
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Other:________________________			

WORK INFORMATION	
Employer:	
Occupation:	Employment Status: ☐ Full time ☐ Part time ☐ Retired ☐ Not Employed

CARE PROVIDER INFORMATION	
Referring Dr.	Name of Practice:
Regular PCP/Dr.	Name of Practice:

INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD TO THE RECEPTIONIST)	
Primary Insurance Name:	
Subscriber's Name (if different):	DOB:
ID #:	Group/Policy #:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	
Name of Secondary Insurance:	
Subscriber's Name (if different):	Birth Date: / /
ID #:	Group/Policy #:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE PRIVATE INSURANCE INFORMATION)			
Insurance Name: ☐ Auto:	☐ Workers Comp:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City:	State:	Zip:
Claim #:	Accident Date: / /	Cause:	
Body part covered on claim:	Remaining PIP Benefits:		

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address:	City:	State:	Zip:

IN CASE OF EMERGENCY		
Name of Spouse, Local Friend, or Relative:		
Relationship to patient:	Home Phone: ( ) -	Alternate Phone: ( ) -

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Patient Intake Information

Name of person receiving treatment: ____

Name of Responsible Party: _________________________ **Relationship to patient:**________________

I understand and agree to pay all debts and outstanding balances for services rendered to the above designated patient, and that payment for these services, whether reimbursed by my insurance plan or not, or made at the time of service or at a later date, are my responsibility. While Parry Physical Therapy Group may assist me in verifying my insurance coverage, I realize that I am responsible to know my insurance benefits and coverage and am liable for all copayments, coinsurance and deductibles. If applicable, I acknowledge that I am responsible to endorse and surrender to Parry Physical Therapy Group, all insurance checks made out to me from my insurance company for physical therapy services. Further, if applicable, I grant this office permission to endorse checks made out to me, to be credited to my account.

____ ____________________________

Signature of patient or person responsible for payment **Date**

Informed Consent: *I grant permission to Parry Physical Therapy Group for treatment in correspondence with either a medical prescription or a physical therapy plan of care, which may include, but is not limited to, therapeutic exercises, manual therapies and modalities. If treatment is rendered under direct access, I understand that I am required to see a medical doctor, DPM, or DDM, to continue treatment beyond the initial 30 days. In granting permission for treatment I release Parry Physical Therapy Group from any liability. I authorize payment of physical therapy benefits to Parry Physical Therapy Group for services rendered by Parry Physical Therapy Group. I authorize release of medical records upon request for settlement of a claim or for application of insurance benefits. I request payment of authorized benefits to be made on my behalf. I certify that information given by me in applying for insurance payment is correct.*

____ ____________________________

Signature of patient or person responsible for payment **Date**

Please forward all payments to: **Jack A Parry, PT, Inc. 361 S Eleventh Street, Ste 2, Quakertown PA 18951**

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Past Medical History

Name: Date: / /

BLOOD PRESSURE	YES	NO		OTHER CONDITIONS	YES	NO
Hypertension				Rheumatoid Arthritis		
Low Blood Pressure				Multiple Sclerosis		
Normal Blood Pressure				Epilepsy		
HEART DISEASE	YES	NO		Gout		
Heart Attack				Diabetes		
Atherosclerotic Disease				Hearing Loss		
Myocardial Infarction				Fainting		
Rheumatic Heart Disease				Polio		
Heart Murmur				Osteoporosis		
MUSCLE CONDITION	YES	NO		Loss of balance		
Carpal Tunnel R/L				Unusual bleeding/discharge		
Tennis Elbow R/L				Wound that won't heal		
Back/Neck Problems				Change in bowel or bladder habits		
Limited Limb Movement				Lumps in body parts		
LUNGS	YES	NO		Unexpected weight loss		
Asthma				Nagging cough > 3 months		
Emphysema				Difficulty swallowing		
Shortness of Breath				Increased pain at night		
JOINT CONDITIONS	YES	NO				
Upper Extremity Dislocation						
Lower Extremity Dislocation						

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS
☐ None ☐ 1-2 x Week ☐ 3-4 x Week ☐ 5+ x Week	☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor	☐ Low ☐ Medium ☐ High	☐ Smoking Packs a day: ______ ☐ Alcohol Drinks a week: ____ ☐ Coffee/Soda Cups a week: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐ YES ☐ NO If yes, please list:____

List all medications you are currently taking:

____

Are you pregnant? ☐ YES ☐ NO If yes, what week? _____________

Have you had any injuries related to work? ☐ YES ☐ NO If yes, what body part and date:__________________

Have you had any auto accidents? ☐ YES ☐ NO If yes, what body part and date:__________________________

Please list any prior surgeries: ____

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Confidential Patient Case History

Date of Injury/Onset of Condition: / /	Date of Surgery: / /
Surgical Procedure:	
Please answer the following questions about your condition/pain.	
How did you injure yourself?	
Describe your symptoms:	
What makes your condition/pain worse?	
What makes your condition/pain better?	

Please check the most appropriate description of you discomfort:

- ☐ Achy
- ☐ Sharp
- ☐ Dull
- ☐ Pins/Needles
- ☐ Tingling
- ☐ Burning
- ☐ Throbbing
- ☐ Cramping
- ☐ Decreased Feeling
- ☐ Other___________________

Please check any other symptoms you might have:

- ☐ Stiffness
- ☐ Loss of Motion
- ☐ Pressure
- ☐ Swelling
- ☐ Popping
- ☐ Clicking
- ☐ Giving way
- ☐ Locking
- ☐ Spasms
- ☐ Dizziness
- ☐ Fainting
- ☐ Nausea

Please check activities that are restricted in ability to perform in an efficient, typical, competent, and expected manner:

- ☐ Standing
- ☐ Sitting
- ☐ Driving
- ☐ Walking
- ☐ Stooping
- ☐ Squatting
- ☐ Stairs
- ☐ Kneeling
- ☐ Bending
- ☐ Reaching
- ☐ Shaving
- ☐ Twisting
- ☐ Making beds
- ☐ Taking out trash
- ☐ Showering
- ☐ Sexual Activities
- ☐ Washing/Drying Hair
- ☐ Lifting objects from the floor
- ☐ Carrying large objects
- ☐ Putting on/off shirt/jacket
- ☐ Putting on/off socks or shoes
- ☐ Putting on/off pants

Is your condition: ☐ Improving ☐ Same ☐ Worsening

Signature:____ Date:________________________________

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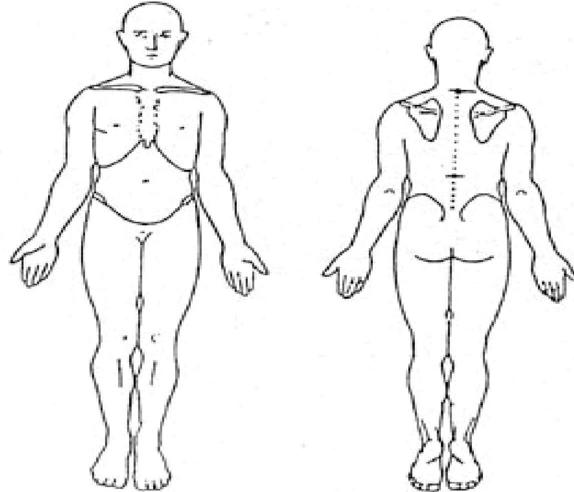
Pain and Symptom Status Report

Name: ________________________________ **Date:** ________________________

Using the symbols below please draw at the location on the body outlines, the type of pain you are experiencing.



Ache	**Burning**	**Numbness (no feeling)**
MMM MM	- - - - - - - - - - - - -	O O O O O O O O

Pins and Needles	**Stabbing**	**Other**
X X X X X X X X X	/ / / / / / / / / / / / / /	★ ★ ★ ★ ★ ★ ★ ★

Chief Complaint and Visual Analog Scale

Your chief complaint is: ____

Date when your first symptom occurred: ______________________________

Second complaint: ____

Third complaint: ____

Please circle one of each below to indicate when pain is better:

Knees bent when sitting or Knees straight when standing

Sitting or Standing **Bending Forward or Bending Backward**

Please circle one of each below to indicate when pain is worse:

Morning or Evening **Weight Bearing or Sitting** **Sitting or Lying Down**

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can get

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can get

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can get

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Patient-Specific Functional Scale - used to quantify activity limitation and measure functional outcome for patients with any orthopedic condition.

Please list three or more list activities that you are unable to do or are having difficulty with because of your pain or injury. Then rate each activity on a scale of 0-10 where 0 is unable to perform the activity and 10 is able to perform the activity at the same level as before your injury or problem.

0	1	2	3	4	5	6	7	8	9	**10**
Unable to perform activity										Able to perform activity at the same level as before injury or problem

Activity	**Score**					
1.						
2.						
3.						
4.						
5.						
6.						
7.						