PARRY
PHYSICAL THERAPY
GROUP
HURT LESS. LIVE MORE.

Patient Intake Information

Name of person receiving treatment: ____

Name of Responsible Party: ________________________ **Relationship to patient:** ______________

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

Emergency Contact: ______________________________ **Relationship to patient:** ______________

Emergency Contact: Home Phone: ____________________ Alternate Phone: ____________________

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 patient **Date**

Please forward all payments to: **Jack A Parry, PT, Inc. 723 Route 113, Suite 6, Souderton, PA 18964**

I understand that Parry Physical Therapy Group operates in an open environment and from time to time other clients may hear myself and the staff talking about my case. I give my permission for this communication to occur in an open environment. If at any time I prefer to have such conversations in private only, I will immediately inform the staff at Parry Physical Therapy Group and they will refrain from public conversation and discuss my care with me in a private treatment room.

____ ______________________________

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

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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		
Irregular Heart Beat				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		Anemia		
Upper Extremity Dislocation				Cancer (kind/location)		
Lower Extremity Dislocation						

Other Medical History (please explain):

Surgical history (other than for current condition):

Have you received therapy during the calendar year? ☐ Yes ☐ No

Please provide details: ☐ PT ☐ OT ☐ SLT Dates of care:______________________________

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: ______ ☐ Check if you have received any cessation counseling in the past year? ☐ Alcohol Drinks per week: _____

Height: __________ Weight: _______________

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

Is this injury related to work? ☐ YES ☐ NO If yes, what body part and date:__________________

Is this injury related to an auto accidents? ☐ YES ☐ NO If yes, what body part and date:__________________________

Do you Feel Depressed? ☐ YES ☐ NO

Have you felt physically, mentally, or emotionally abused in the last 6 months ? ☐ YES ☐ NO

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Not employed
Occupation:____ Employer: _____________________________

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

Please check any other symptoms you might have:

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

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

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

Is your condition: ☐ Improving ☐ Same ☐ Worsening

Signature:____ Date:_________________________________

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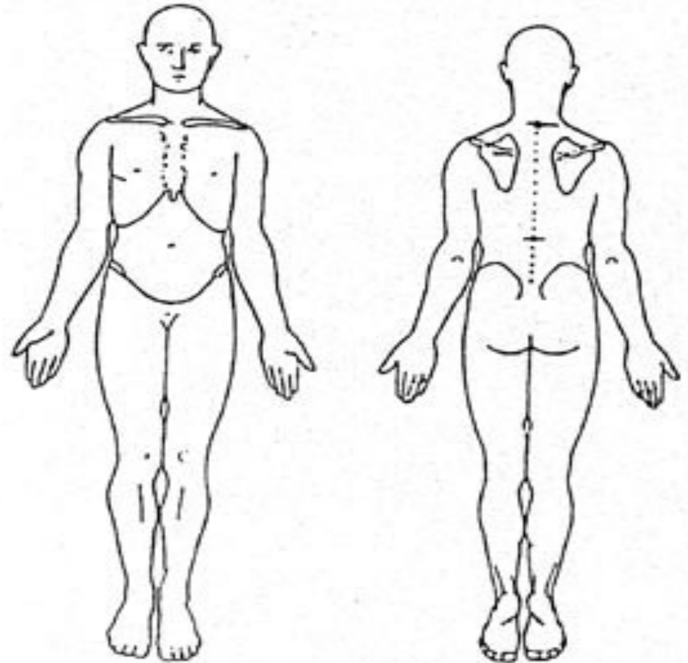
On the body to the right,
please mark where you feel pain.

On the body to the right,
please mark where you feel pain.

Ache	Burning	Numbness (no feeling)
MMM	- - - - - -	OOOOOOO
MMM	- - - - - -	OOOOOOO
MMM	- - - - - -	OOOOOOO

Pins and Needles	Stabbing	Other
XXXX	/////////////	++++++
XXXX	/////////////	++++++
XXXX	/////////////	++++++



Chief Complaint and Visual Analog Scale

Please circle one option below to indicate what makes your pain better:

Hot *or* **Cold**

Please circle one option below indicating when you have LESS pain (you feel better):

BACK PAIN: **Sitting** *or* **Standing** **Lying on your back** *or* **Lying on your belly**

KNEE PAIN: **Sitting** *or* **Standing** **Standing** *or* **Walking**

Front of knee *or* **Sides of knee**

Please circle one of each below to indicate when your 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 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**

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

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Current Medications List - PQRS #130

Name: ____

Date: ____

Prescription	Ordering Physician	Dosage	Frequency	Route
Over-the-counter, herbal, vitamin/mineral/dietary supplement	**Ordering Physician**	**Dosage**	**Frequency**	**Route**