BAY STATE PHYSICAL THERAPY
Physical Therapy at its Best!®

Milton Chiropractic & Rehabilitation INCORPORATED

Worker's Compensation 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
Please explain in detail how the accident occurred:_____
_____
Please list symptoms felt immediately after the accident: _____
_____
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□ WORSENED or □ STAYED SAME since the accident?
Please share any other information that might be important to your diagnosis and treatment: _____
_____

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

Acknowledgement of Office Policies

The following are Bay State Physical Therapy and Milton Chiropractic & Rehabilitation'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 Milton Chiropractic & Rehabilitation 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) appointments in a three (3) week period without notifying Bay State (emergencies considered), 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 Milton Chiropractic & Rehabilitation 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 Milton Chiropractic & Rehabilitation 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 Milton Chiropractic & Rehabilitation's Notice of Information Practices. I understand that Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation 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 Milton Chiropractic & Rehabilitation 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 Milton 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 (Parent/Guardian of Minor): _____ **Date:** _____

Name (Please Print): _____ **DOB:** _____

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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:** _____

_____ **DOB:**_____
Patient Name

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

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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?

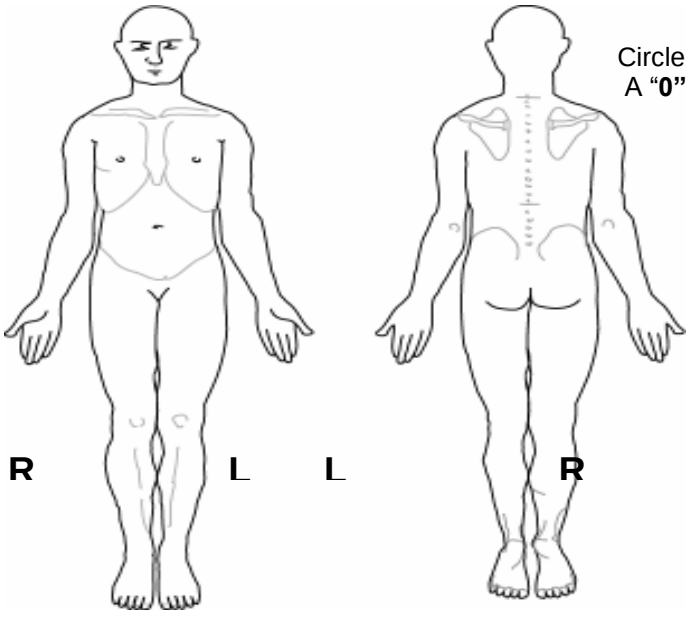
☐ Yes ☐ No

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: XXXXX Numbness: 0000



Circle the number corresponding with the intensity of your symptoms.
A "**0" = No Pain** where as 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

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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 (or you may attach a separate list):

_____ ___/___/_____

_____ ___/___/_____

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 (Parent/Guardian of Minor):_____ DOB: ___/___/__ Date: __/___/___