Longwood Rehabilitative Services, Inc.

Orthopaedic Physical Therapy and Wellness Center
2629 W. State Road 434
Longwood, FL 32779
(407) 774-1716
www.longwoodrehab.com

Patient Intake Form

Patient Information

Verified DL: ☐Yes ☐ No

Last Name:	First Name:	Middle Initial:	
Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	E-mail Address:	
Date of Birth:	SSN:	Sex: ☐Male ☐Female	Marital Status:

Employer Information

Employer Name:	Employment Status: ☐Full Time ☐Part Time ☐Retired		
Address:	City:	State:	Zip Code:
Work Phone Number:	Patient Occupation:		

Emergency Contact Information

Contact Name:	Phone Number:	Relationship to Patient:

Physician Information

Name of Referring Physician:________________________ Telephone Number:________________________

Family Doctor:_____________________________________ Telephone Number:________________________

Additional Questions

Auto related:	Work Related:	Accident Related:	Body Part/Diagnosis:	Date of Injury:
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		

MEDICARE ONLY- Additional Questions

If Medicare, are you currently receiving Home Health Services? ☐Yes ☐No

If yes, Name of Agency?____________Last date of service:______________

Are you currently residing in a Skilled Nursing Facility?☐Yes☐No If Yes, Name of Facility:______________________

If Medicare, have you received PT, OT, or Speech therapy this year? ☐Yes ☐No

If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? ☐Yes ☐No

Patient Signature:____ Date:________________

Longwood
Rehabilitative
Services,Inc.

Orthopaedic Physical Therapy and Wellness Center
2629 W. State Road 434
Longwood, FL 32779
(407) 774-1716
www.longwoodrehab.com

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Name: ______________________ **Hand Dominance:** R L **Date:** ______________

Age: ______________________ **Height:** ______________ **Weight:** ______________

Tell Us About Your Condition

Where and how did your injury/symptoms occur? ☐ Recreation ☐ Home ☐ Work ☐ Auto Accident ☐ Unknown ☐ Other

What activities are limited by this condition? (E.g. lift, reach) ______________________________

What do you expect to accomplish with physical therapy? ______________________________

Are your symptoms: ☐ Constant? ☐ Increasing? ☐Decreasing?

What makes your symptoms better? ______________________________

Worst pain rating: _______ **Best** pain rating: _______

0-10 pain scale (0 = No Pain; 10 = The Most Extreme Pain)

For this injury, has your medical care included :(check those that apply)

☐Surgery: When? ___/___/___ What kind?____________________

☐Injection: When? ___/___/___ Did it Help? ☐ Yes ☐ No

☐Physical therapy If yes, when? ___/___/___to ___/___/__

What was done?______________________________

☐Home Health If yes, when? ___/___/___to ___/___/__

☐Chiropractor If yes, when? ___/___/___to ___/___/___

What was done? ______________________________

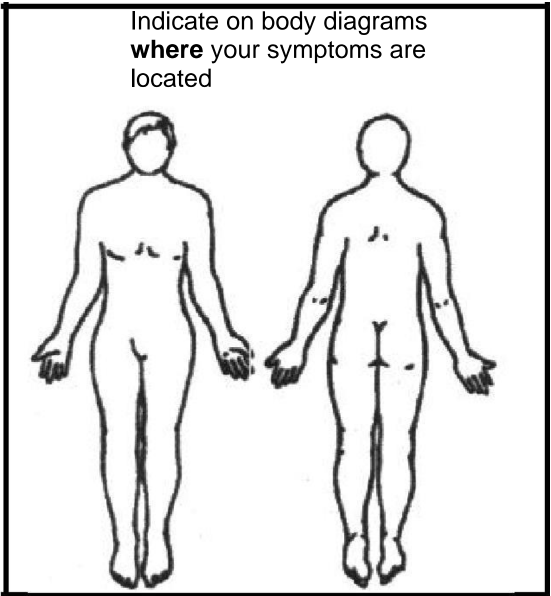
☐Medications: ______________________________

☐X-ray ____________________ ☐MRI ____________________

☐CT scan ____________________ ☐ Other: ____________________

Problems with exercise? ☐ No ☐ Yes

Indicate on body diagrams **where** your symptoms are located



Comments: ______________________

Work Information:

Are you currently working? ☐ No ☐ Yes If yes, numbers of hours per week __________ ☐ Full Duty ☐ Restricted Duty

What are your job responsibilities? ______________________________Estimated return to work date: _________

Additional Comments____

____

____

____

Patient Signature: ______________________________

Longwood
Rehabilitative
Services,Inc.

Orthopaedic Physical Therapy and Wellness Center
2629 W. State Road 434
Longwood, FL 32779
407-774-1716
www.longwoodrehab.com

Medical History

Existing or Relevant Previous Conditions:

Allergies	oYes oNo	Diabetes	oYes oNo	Metal Implants	oYes oNo
Anemia	oYes oNo	Dizzy Spells	oYes oNo	MRSA	oYes oNo
Anxiety	oYes oNo	Emphysema/ Bronchitis	oYes oNo	Multiple Sclerosis	oYes oNo
Arthritis	oYes oNo	Fibromyalgia	oYes oNo	Muscular Disease	oYes oNo
Asthma	oYes oNo	Fractures	oYes oNo	Osteoporosis	oYes oNo
Autoimmune Disorder	oYes oNo	Gallbladder Problems	oYes oNo	Parkinson's	oYes oNo
Cancer	oYes oNo	Headaches	oYes oNo	Rheumatoid Arthritis	oYes oNo
Cardiac Conditions	oYes oNo	Hearing Impairment	oYes oNo	Seizures	oYes oNo
Cardiac Pacemaker	oYes oNo	Hepatitis	oYes oNo	Smoking	oYes oNo
Chemical Dependency	oYes oNo	High Cholesterol	oYes oNo	Speech Problems	oYes oNo
Circulation Problems	oYes oNo	High/ Low Blood Pressure	oYes oNo	Strokes	oYes oNo
COVID-19	oYes oNo	HIV/ AIDS	oYes oNo	Thyroid Disease	oYes oNo
Currently Pregnant	oYes oNo	Incontinence	oYes oNo	Tuberculosis	oYes oNo
Depression	oYes oNo	Kidney Problems	oYes oNo	Vision Problems	oYes oNo

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate date /Describe any other Conditions

Fall History

- o Injury as a result of a fall in the past year?
- o Two or more falls in the last year?
- o Patient is at risk for falls?

Surgical History

Body Region: ______________________ Surgery Type: ________________________ Date: ______________, _______, __________

Body Region: ______________________ Surgery Type: ________________________ Date: ______________, _______, __________

Body Region: ______________________ Surgery Type: ________________________ Date: ______________, _______, __________

Body Region: ______________________ Surgery Type: ________________________ Date: ______________, _______, __________

Current Medications

Drug: ________________ Dosage: _______ Frequency: ____________ Route: ____________ Reason Taking: _______________________

Drug: ________________ Dosage: _______ Frequency: ____________ Route: ____________ Reason Taking: _______________________

Drug: ________________ Dosage: _______ Frequency: ____________ Route: ____________ Reason Taking: _______________________

Drug: ________________ Dosage: _______ Frequency: ____________ Route: ____________ Reason Taking: _______________________

© 2021

Longwood Rehabilitative Services

May we text or send you E-Mails to remind you of future appointments?

Please circle one. Text: Y or N E-Mail: Y or N

May we leave messages about your care on your voicemail? Y or N

May we discuss your care with another person? If yes, please the list name(s).

____

Please tell us how you heard about Longwood Rehab? ________________________

<u>CONSENT FOR CARE AND TREATMENT</u>

I, the undersigned, do hereby agree and give my consent for Longwood Rehabilitative Services, Inc. to furnish physical therapy/health care and treatment to____considered necessary and proper in diagnosing and/or treating his/her physical condition.

(Print Patient Name)

PATIENT or GUARDIAN SIGNATURE:_____________________________________ DATE:_________________

<u>BENEFIT ASSIGNMENT</u>

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and all third party payors to Longwood Rehabilitative Services, Inc. I hereby authorize said assignee to release all information necessary, including Medical records, to secure payment. A photocopy of this assignment is to be considered as valid as the original.

PATIENT/GUARDIAN SIGNATURE:_______________________________________ DATE:________________

<u>ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES</u>

By signing or initialing below, I confirm that I have received a copy of the Notice of Privacy Practices for Longwood Rehabilitative Services, Inc.

PATIENT/GUARDIAN SIGNATURE:______________________________________ DATE:_______________