

# Custom Care Physical Therapy

Amy Baram, MSPT  
customcarePTwithAmy@gmail.com  
610-717-8837

Patient intake form:

Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Address: Street \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

DOB: \_\_\_\_\_

Age: \_\_\_\_\_

Home phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Email: \_\_\_\_\_

How do you prefer I contact you? \_\_\_\_\_

If under 18, Parent Guardian's Name: \_\_\_\_\_

Do you have a prescription for physical therapy? YES/ NO

Referring Physician Name: \_\_\_\_\_

Referring Physician phone number: \_\_\_\_\_

Diagnosis/Body Part: \_\_\_\_\_

Date of injury if applicable: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency contact phone number: \_\_\_\_\_

Relationship to self: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Medical Intake Form:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

History of Present Illness/Injury/concern in your own words: \_\_\_\_\_

\_\_\_\_\_

Date of onset if applicable: \_\_\_\_\_

Diagnosis as stated to you by your physician: \_\_\_\_\_

Have you been hospitalized for the present condition? \_\_\_\_\_ Date: \_\_\_\_\_

Have you had surgery for the present condition? \_\_\_\_\_ Date: \_\_\_\_\_

Have you received any treatment of any kind for this condition? (PT/chiropractor/massage therapy/personal fitness training?) \_\_\_\_\_ Date: \_\_\_\_\_

Have you had any diagnostic tests related to this concern? (Xray, MRI, Bone Scan, CAT Scan, EMG)

Results: \_\_\_\_\_

\_\_\_\_\_

Have any of the following symptoms occurred with this problem: (circle) numbness, tingling, vomiting, unexpected weight loss or gain, blood in stool or urine, urinary incontinence, night sweats, fevers, chills, vision changes, fatigue, weakness, headaches, dizziness, fainting spells?

## Pain Scale:

On a scale of 0 to 10, (0 being no pain and 10 being unbearable pain requiring hospitalization), please rate your pain at present \_\_\_\_\_ pain at its worse \_\_\_\_\_

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## Personal Health Information:

Have you ever, or are you currently being treated for any of the following conditions?

Diabetes:	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A, B, C	<input type="radio"/> Yes <input type="radio"/> No
Headaches	<input type="radio"/> Yes <input type="radio"/> No	HIV/Aids	<input type="radio"/> Yes <input type="radio"/> No
Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble	<input type="radio"/> Yes <input type="radio"/> No
Fainting Spells	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Stroke	<input type="radio"/> Yes <input type="radio"/> No	Hernia	<input type="radio"/> Yes <input type="radio"/> No
Pregnancy	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No
Seizures	<input type="radio"/> Yes <input type="radio"/> No	Bowel/Bladder Abnormalities	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Liver/Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No
Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Smoking	<input type="radio"/> Yes <input type="radio"/> No
Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Skin Abnormalities	<input type="radio"/> Yes <input type="radio"/> No
Back Injury	<input type="radio"/> Yes <input type="radio"/> No	Nausea/Vomiting	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Allergies	<input type="radio"/> Yes <input type="radio"/> No
Bleeding disorders	<input type="radio"/> Yes <input type="radio"/> No	List: _____	
Fracture	<input type="radio"/> Yes <input type="radio"/> No	Ringin in your ears	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No
Metal Implants	<input type="radio"/> Yes <input type="radio"/> No	Surgeries: List w/dates:	
Respiratory Problems	<input type="radio"/> Yes <input type="radio"/> No	_____	
Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No		

Anything else you need to elaborate on from above?: \_\_\_\_\_

Anything else you feel I need to know?: \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Custom Care PT staff will depend on statements made by the patient, information provided in patient's medical history and other available information to evaluate a patient's condition and to decide on the best treatment plan. Relevant information from your visit will be documented and stored in your medical records. Any medical and personal information whether verbally reported, written or stored in your medical file will be confidential unless specified to be released to specific named individuals.

If you are unclear about your treatment, your financial responsibility or the protection of your records, please contact Amy Baram of Custom Care PT at any time.

## Statement of Patient Financial Responsibility

Custom Care PT, LLC, is pleased to be your chosen physical therapy provider. The services you have elected to receive imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full on the date services are provided.

By signing below, I acknowledge that I have decided to pursue physical therapy and related services without using medical health insurance benefits. I understand that this means no insurance company will be billed by Custom Care PT for any services I receive, and that I am fully responsible for payment. If you should be using a Health Spending Account (HSA), it is the patient's responsibility to be sure that services provided by Custom Care PT are covered based on the terms of your HSA account.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent Signature for minor: \_\_\_\_\_ Date: \_\_\_\_\_

## Confidentiality Permission/Release Agreement

I authorize Custom Care PT to share/discuss my medical history and current plan of care with the person(s) listed below. (Physician(s)/Family members).

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

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## Consent to Treat: (please initial)

I hereby consent Custom Care PT to provide physical therapy and related services as deemed appropriate and necessary for my condition and personal goals\_\_\_\_\_.

I authorize the release of any information necessary for my ongoing care as documented above\_\_\_\_\_.

I consent that information regarding my care may be communicated via voicemail/text and/or email to me and named individuals\_\_\_\_\_.

I agree to pay Custom Care PT for each visit fee at the time of service\_\_\_\_\_.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent Signature for minor: \_\_\_\_\_ Date: \_\_\_\_\_

## COVID-19 Liability and Indemnity Waiver:

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing. Six feet of distancing is not feasible for a manual physical therapist. I further acknowledge that Custom Care Physical Therapy has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.

I further acknowledge that Custom Care Physical Therapy cannot guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 is possible, and efforts will be put in place to minimize this risk.

I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I attest that:

\*\* I am not currently experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, headache, sore throat, or new loss of taste or smell.

\*\* I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19 in the last 14 days.

I understand that this COVID release discharges Custom Care Physical Therapy from any liability or claim Custom Care Physical Therapy with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Custom Care Physical Therapy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

