SOAR Physical Therapy & Acupuncture

2123 Route 35, Sea Girt, NJ • Phone 732-449-2001 • Fax 732-449-2238 • soarpt.com

Administrative Intake Sheet

Patient Name: _____
(Last) (First) (M.I.)

Birthdate: _____ Gender: ☐ Male ☐ Female

Street Address: _____
City: _____State: _____ Zip: _____

1st Preferred Phone #: _____ (☐ Home ☐ Work ☐ Mobile)
2nd Preferred Phone #: _____ (☐ Home ☐ Work ☐ Mobile)
3rd Preferred Phone #: _____ (☐ Home ☐ Work ☐ Mobile)
E-Mail: _____

How Did You Choose Our Practice?
☐ I Was a Previous Patient ☐ Word of Mouth ☐ Our Web Page ☐ Facebook ☐ YELP!
☐ Google/Search Engine ☐ Newspaper Ad ☐ Managed Care Network ☐ Yellow Pages
☐ Doctor Recommended ☐ SOAR Education Seminar
☐ Other _____

Who Can We Thank For Referring You?_____

Occupation: _____☐ Full-Time ☐ Part-Time
Currently Working: ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time ☐ Light Duty

Any Referring Physician: _____
Their Address & Phone: _____
Next Follow-Up Appointment Date: _____
Please advise us of future doctor appointments so we can provide progress reports.

Primary Physician (if different than referring):_____
Their Address & Phone: _____

Surgeon (if different than referring):_____
Their Address & Phone: _____

Any Case Manager: _____
Their Address & Phone: _____

Emergency Contact Name & Phone: _____

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Clinical Intake Sheet

Patient Name: _____
(Last) (First) (M.I.)

Birthdate: _____ Gender: ☐ Male ☐ Female

Periodically, we provide clinical internship training for students. Please indicate your preference:
☐ I am willing to be treated by a physical therapy intern under the supervision of a S.O.A.R. physical therapist.
☐ I am not willing to be treated by a physical therapy intern under the supervision of a S.O.A.R. physical therapist.

Is your general health: ☐ Good ☐ Fair ☐ Poor

Family Health History (Indicate if your mother, father, brother, sister, aunt, uncle, grandmother or grandfather has had any of the following - & age of onset, if known):

Heart Disease: _____ Hypertension: _____
Stroke: _____ Diabetes: _____
Cancer: _____ Psychological: _____
Arthritis: _____ Osteoporosis: _____
Other: _____

Past Medical/Surgical History - Please check if you have ever had:

☐ Allergy to _____
☐ Alzheimer's/Dementia
☐ Anemia/Blood Disorder _____
☐ Anxiety
☐ Arthritis/Osteoarthritis
☐ Asthma
☐ Autoimmune Disease (RA, lupus, sjogren's, psoriatic)
☐ Cancer or Tumor _____
☐ Cardiac Pacemaker
☐ Cardiac/Heart Conditions _____
☐ Chemical Dependency
☐ Circulation/Vascular Problems/PVD
☐ Cognitive/Memory Loss_____
☐ Depression
☐ Diabetes/High Blood Sugar
☐ Dizzyness/Vertigo
☐ Emphyzema/COPD/Bronchitis(chronic)
☐ Fibromyalgia
☐ Fractures/Broken Bones _____
☐ Gallbladder Problems
☐ Hepatitis
☐ Hypertension/High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Incontinence
☐ Kidney Disease
☐ Metal/Surgical Implants
☐ Multiple Sclerosis
☐ Osteoporosis/Osteopenia
☐ Parkinson's Disease
☐ Pregnant (Possibly/Current Only)
☐ Peripheral Neuropathy
☐ Seizures/Epilepsy
☐ Speech Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Vision Problems_____
☐ **None of Above**

☐ Other Conditions:_____
_____

Past Surgeries:

Type	Date

Current Medications, AND Supplements/ Vitamins:

Name	Reason	Dose (Mg)	Times/Day

Brief Description of Problem: _____
Involved Side: □ Left □ Right □ N/A Dominant Side: □ Left □ Right
Current Diagnosis/Area Injured: _____
Injury Date: _____ Current Surgery Date (if any): _____
Severity of Problem: □ Very Minor □ Minor □ Moderate □ Severe □ Very Severe
What are you doing for this problem now? _____
What are your goals for physical therapy? _____

Within the past year, have you had any of these symptoms? (Check all that apply)

□ Chest Pain
□ Nausea or Vomiting
□ Hoarseness
□ Weight Loss or Gain
□ Coordination Problems
□ Headaches
□ Difficulty Walking
□ Sensory Numbness
□ Difficulty Sleeping
□ Loss of Appetite
□ Cough
□ Bowel Problems
□ Dizziness or Blackouts
□ Fever, Chills or Sweats
□ Loss of Balance
□ Vision Problems
□ Pain at Night
□ Stabbing pains
□ Heart Palpitations
□ Difficulty Swallowing
□ Shortness of Breath
□ Urinary Problems
□ Weakness in Arms or Leg
□ Hearing Problems
□ Joint Pain or Swelling
□ Repeated Falls
□ Other_____

Within the past year, have you had any of the following tests?

□ Angiogram
□ Myelogram
□ CT Scan
□ X-rays
□ MRI
□ Bone Scan
□ Stress Test
□ EMG
□ Arthroscopy
□ NCV (nerve conduction velocity)
□ EKG
□ Other: _____

Signature: _____ Date: _____
Patient (Parent or Guardian if patient is a minor)

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PRIVACY NOTICE

Your Information, Your Rights, Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
You have the right to:
• Get a copy of your paper or electronic medical record
• Correct your paper or electronic medical record
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we've shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
• Tell family and friends about your condition
• Provide disaster relief
• Market our services

Our Uses and Disclosures
We may use and share your information as we:
• Treat you
• Run our organization
• Bill for your services
• Help with public health and safety issues
• Do research
• Comply with the law
• Respond to organ and tissue donation requests
• Work with a medical examiner or funeral director
• Address workers' compensation, law enforcement, and other government requests
• Respond to lawsuits and legal actions

The undersigned has read this notice and has received a copy of this signed notice and the Notice of Privacy Practices, if requested.

Name _____ Signature _____ Date_____

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Therapeutic Massage / Bodywork Informed Consent

Client/patient Name_____ DOB_____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ☐ Yes ☐ No
If yes, How recently_____

What are your massage or bodywork goals?_____

What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

If you answer yes to any of the following questions, please explain as clearly as possible

☐yes ☐no Do you frequently suffer from stress?_____
☐yes ☐no Are you pregnant?_____
☐yes ☐no Do you experience frequent headaches?_____
☐yes ☐no Are you wearing contact lenses?_____
☐yes ☐no Are you wearing dentures?_____
☐yes ☐no Do you have any contagious diseases?_____
☐yes ☐no Do you bruise easily?_____
☐yes ☐no Do you have tension or soreness in a specific area?_____
_____
☐yes ☐no Are you sensitive to touch or pressure in any area_____
☐yes ☐no Any injuries in the past 2 years?_____
☐yes ☐no Do you have varicose veins?_____

I understand that massage/bodywork is provided for the basic purpose of relaxation and relief of muscle tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination diagnosis or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments diagnose prescribe or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in medical profile and understand that there shall be no liability on the practitioners part should I fail to do so.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

Client Signature_____ Date_____
(parent or guardian if client/patient is a minor)

Practitioner Signature_____ Date_____

No-Show / Cancellation Policy

Please Read Carefully

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. Due to our one-on-one 60-minute treatments, missed appointments are a significant inconvenience to your treatment, the clinic and other patients.

1. Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $50.00 office visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

2. We reserve your appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hour notice allows us to place another patient in your cancelled appointment time, to receive needed treatment.

3. Certain accident claims adjusters expect regular attendance to therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioners to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

4. Your clinician will develop a specific plan of care based on your individual goals/outcomes and physical impairments. Adhering to this plan of care (frequency/duration) is crucial to your outcome.

5. At our discretion, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

_____initial here to acknowledge that you've read and fully understand this policy

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Signature: _____ Date: _____
Patient/Insured (Parent or Guardian if patient is a minor)

Signature: _____ Date: _____
Person accepting responsibility for fees & providing a copy of their credit/debit card

Witness: _____ Date: _____