FREEBORN WELLNESS
COMPLETE INDUSTRIAL OT & PT

Intake Form

Personal Information

Name: ____

Date of Birth: ____/____/______ Age: ______ Height: ______ Weight: _______ Gender: _______

Primary Phone #: __________________________ Alternate Phone #: ______________________

Preferred Contact Method: ❑ Call ❑ Text May we leave a detailed message? ❑ Yes ❑ No

Home Address: _________________________ City: ______________ ST: ____ Zip Code: ______

Email: ____

Insurance Information

Injured Worker?

Injury Diagnosis: ____

Claim #: ________________ Date of Injury: ____/____/______ Last Day Worked: ____/____/____

Describe the Injury/Body Part: ____

____

Describe Symptoms: ____

Employer: __________________________________ How long on the job prior to injury? _______

Job Title (at the time of injury): ________________________________ Part-Time Full-Time

Are you currently working? ❑ Yes ❑ No If so, where? ___________________________

Any job modifications:____

Commercial Insurance?

Primary Insurance Company: ____

Primary Insurers Name: ____ DOB: ____/____/____

Secondary Insurance: ____

Primary Insurers Name: ____ DOB: ____/____/____

Medical Information

Diagnostic Investigation: *Please list approximate dates.*

X-Rays ❑ Yes ❑ Current Injury; Results: ____

CT Scan ❑ Yes ❑ Current Injury; Results: ____

MRI ❑ Yes ❑ Current Injury; Results: ____

EMG/NCS ❑ Yes ❑ Current Injury; Results: ____

Myelogram ❑ Yes ❑ Current Injury; Results: ____

Intake Form

Surgeries: ____

Medications:

Prescription Medications: ❏ Yes ❏ No - If *YES*, please specify: ____________________________

Non-Prescription Medications: ❏ Yes ❏ No - If *YES*, please specify: ________________________

Medical Devices (prosthetics, etc.): ❏ Yes ❏ No - If *YES*, please specify: ____________________

Other Medical History: ____

Previous Treatments: *List approximate dates, results of treatment.*

Physical Therapy: ❏ Yes; ____

Occupational Therapy: ❏ Yes; ____

Pain Program: ❏ Yes; ____

Chiropractic: ❏ Yes; ____

Psychological Therapy: ❏ Yes; ____

Biofeedback: ❏ Yes; ____

Massage Therapy: ❏Yes; ____

Acupuncture: ❏ Yes; ____

Other: ❏ Yes; ____

Pain Ratings:

In the last 30 days, what was your pain level 0/10?

What was your worst pain level? ____/10; Comments: _________________________________

What was your best pain level? ____/10; Comments: __________________________________

Current pain level? ____/10; Comments: ____

What pain level could you tolerate while working? ____/10; Comments: ____________________

Social History

❏ Single ❏ Married (their name: ______________) ❏Domestic Partner (their name: _____________)

Kids: _______ Do you use tobacco products? ❏ Daily ❏ Some Days ❏ Quit ❏ Passive ❏ Never

Packs per Day: ______ Years Smoked: ______ Date Quit: _____

Do you drink alcohol? ❏ Yes ❏ No ❏ Quit / Drinks per Day: __ Drinks per Week: __ Date Quit: ___

Do you use recreational drugs? ❏ Never ❏ Yes / Use per Week: ________ Date Quit: __________

Living Environment (i.e 2-story house, apartment): ____

Who lives with you: _________________________________

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Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
TOTALS				

Emergency Contact

Name: ______________________ Relationship: _____________ Phone #: ____________________

Physician Information

Primary Care Physician (PCP): ____

Name of Clinic/Hospital: ____

Therapy Policies

Consent and Acknowledgement Receipt of Notice of Privacy Practices:
I hereby consent to evaluations, procedures, and/or treatments recommended by my therapist as necessary in their judgment. By signing this form, I acknowledge that I have received a copy of the Freeborn Wellness's HIPPA and Privacy Policies. I understand that Freeborn Wellness supports the higher education of students of Occupational and Physical Therapy. Students may observe the treating therapist, assist, and participate in the ongoing therapy by Freeborn Wellness.

Initial____________

Financial Responsibility:
It is the clients responsibility to know what their insurance will or will not cover. By signing this disclaimer, I accept responsibility for payment of any and all expenses that are not covered by my insurance. I agree that, if for any reason, my insurance company fails to reimburse any portion of a claim for services at this clinic, it is my responsibility to pay what is owed to Freeborn Wellness. Please note that quotes obtained from verification are not a guarantee of coverage.

Intake Form

Please note: If your insurance provider and/or insurance coverage should change while receiving services, please notify us immediately in order to avoid a lapse in coverage. If you fail to notify Freeborn Wellness, you will be responsible for any unpaid claims. This may cause your personal information to be sent to the wrong insurance organization which can lead to a lapse in privacy.

Initial____________

No Call/No Show/ Late Arrival Policy:

In an effort to provide effective and efficient treatment to all of our clients, it is the policy of Freeborn Wellness that all appointment cancellations are to be made at least 24 hours prior to the scheduled appointment time. If an appointment is not canceled over 24 hours in advance and the client fails to attend their scheduled session, Freeborn Wellness reserves the right to charge the client a $100.00 fee, per occurrence. As this fee is not billable to any insurance company, the client accepts full responsibility to pay this late fee. If the client is more than 15 minutes late for an appointment, Freeborn Wellness reserves the right to shorten the clients standard appointment time as needed. Please contact us at 360-870-2473 to cancel an appointment, or to let us know you will be running late. If no one is available to answer your call, please leave a message stating your name, the day of and time of the appointment, your therapist name and that you will be arriving late, or the reason you are canceling.

Initial____________

Three Strike Policy:

If your appointment is not kept due to a "no call/no show" or late developing situation - regardless of the reason, the missed appointment will be counted as a strike. After three strikes, Freeborn Wellness reserves the right to stop providing services to the client. The **latest a cancellation call is considered acceptable is 24 hours prior to the date and time therapy is to take place.** Freeborn Wellness implements this policy because it is in the best interest of the client to participate in services within the intervals set forth and due to the considerable difficulty for all parties to reschedule visits.

Initial____________

Return Check and Late Payment Fees:

Freeborn Wellness will assign a $30 fee for all returned checks. Freeborn Wellness will assign a $25 late fee for any payments received after 60 days of the invoice date. All accounts delinquent after 60 days will incur an interest charge of 1.5% monthly. Should my account become delinquent and referred to any third party for collection efforts, I agree to pay all attorney's fee, court fees, and collection expenses.

Initial___________

Intake Form

Infection Control Policy:

All individuals shall telephone to cancel and reschedule appointments when a participating family member has one or more symptoms of a contagious disease. This will aid in the protection and health of the staff, and all others involved in the session/environment. Symptoms: fever > 100°F, vomiting/nausea, open/draining lesion, lice, chicken pox, measles, productive cough, impetigo, conjunctivitis/pink eye, strep throat, diarrhea, any other contagious disease not listed.

Initial____________

Communication:

Freeborn Wellness uses various forms of electronic communication to stay in contact with our clients. Some of those include email, cell phone, and texting. I hereby give permission to Freeborn Wellness to leave detailed messages on my voicemail.

Initial____________

By signing I hereby authorize the release of all information to secure payment of insurance benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as the original.

I, the undersigned, understand and agree to the above policies.

Client Signature:____ Date:____/____/_____

Freeborn Wellness
No Show/Cancellation Policy

As a valued patient of Freeborn Wellness, we want to be able to provide effective and efficient treatment to all of our clients. It is the policy of Freeborn Wellness that **all appointment cancellations are to be made at least 24 hours prior to the scheduled appointment time.** Freeborn Wellness implements this policy because it is in the best interest of the client to participate in services within the intervals set forth, and the considerable difficulty for all parties to reschedule visits.

If an appointment is not canceled over 24 hours in advance and the client fails to attend their scheduled session, Freeborn Wellness reserves the right to charge the client a $50.00 fee, per occurrence. As this fee is not billable to any insurance company, the client accepts full responsibility to pay this late fee.

Notifying us of your schedule change with a minimum of 24 hours allows us to work around your schedule along with ours to provide treatments to other patients.

I, the undersigned, understand and agree to the above policy.

Print Name: ______________________________ Date: ___/___/___

Signature: ____

FREEBORN WELLNESS
COMPLETE INDUSTRIAL OT & PT

Name: ______________________________ Date: ______________

Patient-Specific Functional Scale

Please identify at least three important activities that you are unable to do or have difficulty doing as a result of your current problem. Write these down. Then rate your ability to do the activities in the last week by circling the appropriate number.

Activity 1: ______________________________

unable to perform	0	1	2	3	4	5	6	7	8	9	10	able to perform at pre-injury level

Activity 2: ______________________________

unable to perform	0	1	2	3	4	5	6	7	8	9	10	able to perform at pre-injury level

Activity 3: ______________________________

unable to perform	0	1	2	3	4	5	6	7	8	9	10	able to perform at pre-injury level

Activity 4: ______________________________

unable to perform	0	1	2	3	4	5	6	7	8	9	10	able to perform at pre-injury level

Activity 5: ______________________________

unable to perform	0	1	2	3	4	5	6	7	8	9	10	able to perform at pre-injury level

SCORE: Sum of individual #s divided by the total # of activities: [ ]

____

Patient Goals: ______________________________

Functional Capacity Evaluation Consent Form

You are here to take some tests to measure how you can do various tasks. These tests are like some that may be required of you at work. The results of these tests will be provided to you, your attorney, if represented, your doctors, and your workers compensation insurance carrier. This form is to make sure that you understand the test and what you will be asked to do. Please read each question and answer it so that we will know that you understand what you are about to do. You will receive a copy of this form to keep with you and you may look at it at any time.

____

(Print your name)

1. Have you used any drugs or alcohol during the last three days? This Includes any pain or prescription drugs. ☐ Yes ☐ No

If "Yes", please describe the type of drugs or alcohol you have used, when you took the drugs or alcohol, and how much you took.

____

2. It is important that you understand how to do each of the tasks. You will be given verbal instructions as to how to perform each task. When the person giving you the test is finished with the instructions, they will ask you if you understand. If you do not understand, you have the right to ask for an actual demonstration of the task. You should not do any requested task until you understand what you are being asked to do. Do you agree not to do a task until you fully understand what you are asked to do? ☐ Yes ☐ No

3. This test is designed to determine your ability to perform different tasks. It is important that you give your best safe effort on each task. Do you agree to give your best safe effort on each task? ☐ Yes ☐ No

If "No", why not?

____

4. Some of the tasks you may be asked to do may be hard to do. The person giving you the test may decide that you have performed the task incorrectly and ask you to repeat the task. Do you agree to repeat the tasks if asked to do so? ☐ Yes ☐ No

If “No”, why not?

___

5. Do you understand that you may refuse to do any task? ☐ Yes ☐ No

a. If you refuse to do the task, the report will have to note that you refused and you will be allowed to explain what you did not think you should do. Your explanation will be included “word-for-word” in any final report. Do you agree to give an explanation to the person giving the test if you refuse to perform a task?
☐ Yes ☐
No

If “No”, why not?

___

b. These tests are designed to reduce the risk of injury. You are the only person who can tell the person giving you the test if you have an increase in discomfort or pain while you are performing the tasks. If your pain increases while doing the tasks, it is very important that you immediately tell the person giving you the test and describe the location and type of pain as accurately as possible so that they can decide if it is safe for you to continue. Even if they feel it is safe to proceed, but you do not wish to continue the testing, you have the right to stop the testing. However, you will be asked to explain why you do not want to go forward with any further testing. The written report will include your explanation “word-for-word”. Do you agree to tell the person giving you the test if your pain or discomfort increases while doing a task? ☐ Yes ☐ No

If “No”, why not?

___

6. You may get copies of any and all records used in preparing the final report. Do you understand you have a right to get copies? ☐ Yes ☐ No

7. Are you ready to start taking the test? ☐ Yes ☐
No

If “No”, why not?

___

Signature: ____ Today’s Date: ______________