

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: _____

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: _____

Intake Form

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: _____

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: _____

