Connect Physical Therapy, PLLC
4500 36th Ave S Ste 100
Fargo, ND 58104
(701)-318-4731

Patient Information

Name: ______________________________________ Date of Birth: ______________________

Address: ____

Phone Number: _________________________________ Email: ___________________________

Occupation & Employer: ____

Emergency Contact & Phone Number: ____

Primary Care Provider Name & Phone Number: _______________________________________

Insurance Information

Company: ____________________________ Address: __________________________________

Subscriber/Policy Number: ___________________________ Group Number: ______________

Insured Name: _________________________ DOB: _____________ Relation: ______________

Medical History

What is/are your main complaint(s)? ☐ Pain ☐ Numbness/Tingling ☐ Stiffness ☐ Dizziness
☐ Balance loss ☐ Other: ____
What body part are you here for today? _____________________________ ☐ Left ☐ Right
When did this problem begin? ____
Was there a specific injury? ☐ Yes ☐ No (If yes, please describe): ________________________
____
Have you ever had physical therapy for this problem? ☐ Yes ☐ No
Have you had physical therapy this calendar year? ☐ Yes ☐ No
Is your injury work related? ☐ Yes ☐ No
Is your injury related to a motor vehicle accident? ☐ Yes ☐ No
If you have pain, please rate on a scale of 0 to 10 (0 = no pain & 10 worse imaginable)
At this current time: /10 Worst in the past 24 hours: /10 Best in past 24 hours: /10
List any orthopedic surgeries that you have had: ______________________________________
____
List any other surgeries that you have had: ____
____

Diagnostic Testing: Have you had any of the following tests for your current problem:
☐ X-ray ☐ MRI ☐ CT scan ☐ EMG/Nerve Conduction Study ☐ Other: _____________
Results (if known): ____

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Medical History: Please check any conditions that you have

☐ Diabetes ☐ Stroke ☐ TIA (mini stroke)
☐ Heart Arrhythmia ☐ Coronary Heart Disease ☐ High BP
☐ Heart Attack ☐ High Cholesterol ☐ Depression
☐ Rheumatoid Arthritis ☐ Liver Disease ☐ Kidney Disease
☐ Neuropathy ☐ Acid Reflux ☐ Osteoarthritis
☐ Cancer Type: ______________________________
☐ Other: ______________________________
☐ I do not have any medical problems

Are you allergic to latex? ☐ Yes ☐ No Do you exercise regularly? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No Do you have a pacemaker or defibrillator? ☐ Yes ☐ No
Female Patients: Is there any possibility that you are pregnant? ☐ Yes ☐ No

Review of Systems: Are you currently having, or have you had, problems with: ☐ None
Bleeding Disorders? ☐ Yes ☐ No Heart or Chest Pain? ☐ Yes ☐ No GI Ulcers? ☐ Yes ☐ No
Numbness/Tingling? ☐ Yes ☐ No Lungs or Breathing? ☐ Yes ☐ No

Medications: Do you currently take any medications, vitamins, supplements or herbs:
☐ Yes ☐ No If yes, please provide a current list.

Goals: Please list the goal(s) that you hope to achieve by attending physical therapy:
____

COVID-19 Waiver

I understand that because this treatment involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless Connect Physical Therapy from any claims related thereto. I hereby give my consent to receive treatment. ***(INITIALS REQUIRED)*** ____________

HIPAA POLICY

Connect Physical Therapy, PLLC ensures that information about me and my condition, or reason for receiving services, will remain private and be fully disclosed ONLY upon my approval. I acknowledge Connect Physical Therapy, PLLC Privacy and HIPAA Policy.
(INITIALS REQUIRED) ____________________

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FINANCIAL POLICY
I authorize that direct payment be made directly to Connect Physical Therapy, PLLC. I further understand that my insurance company may or may not cover the services rendered by Connect Physical Therapy, PLLC and that I am responsible for any and all remaining charges. I understand that it is my responsibility to check with my insurance company about my insurance plan benefits for physical therapy services and that Connect Physical Therapy, PLLC does not automatically check coverage information. I also agree that my balance may not exceed $300 at any time, with the exception of an authorized payment plan that I have discussed with Connect Physical Therapy, PLLC.

I understand that if I do not make a best effort to reschedule an appointment within 4 hours of that appointment, or if I miss an appointment unannounced, my account may be charged a $25 fee that is not eligible for insurance reimbursement.
(INITIALS REQUIRED) _______________

CONSENT TO CARE
Thank you for choosing Connect Physical Therapy, PLLC as your physical therapy, health, and wellness provider. By signing this form, you are giving consent for Connect Physical Therapy, PLLC to provide the desired services as requested by either yourself or your family member(s).

By filling out the intake form, you are attesting that: I, the undersigned, have given full disclosure of any and all relevant past medical history that may impact, influence, or contraindicate the prescribed services provided by Connect Physical Therapy, PLLC. I do hereby agree and give my consent to receive physical therapy and/or wellness services which are deemed medically necessary as dictated by prudent medical practices by my illness, injury, or condition any provided by authorized personnel of Connect Physical Therapy, PLLC. I understand that Connect Physical Therapy, PLLC is fully licensed and its providing therapists are highly trained and skilled. Connect Physical Therapy, PLLC will ensure that the service they provide is safe, appropriate, and indicated.

While Connect Physical Therapy, PLLC fully intends to give service that offers no harm, I understand that there is *ALWAYS THE POTENTIAL FOR AN UNFORESEEN ACCIDENT TO OCCUR*. Should this be the case, I recognize that Connect Physical Therapy, PLLC has taken every necessary precaution to protect me, and therefore, *I DO NOT HOLD Connect Physical Therapy, PLLC LIABLE FOR ANY UNFORESEEN INJURY*. ***(INITIALS REQUIRED)*** ______________

The above is true and correct to the best of my knowledge.

Patient Signature: ___________________________________ Date: _________________

Parent/Guardian Signature (if patient a minor): ____________________________________