Patient History Intake Form

Patient Name: _____ Date: _____

1. Please describe the problem that brings you here, along with how and when it happened.

_____

_____

_____

_____

2. Please check whether this problem is

- ◉ Chronic (meaning persisting for a long time or constantly recurring) or
- ○ Acute (meaning a rapid onset and occurred recently.)

3. Date of Injury:_____ Please be specific as possible.

4. Date of Surgery, if any:_____ Type of Surgery: _____

5. What makes the problem feel worse?

_____

6. What makes the problem feel better?

_____

7. What treatment have you had for this problem?
(X-Ray, MRI, Injections, Medications, acupuncture, chiropractic, etc.)

_____

8. Date and location of last imaging test?

_____

9. Current medications and supplements:

_____

_____

10. Does the discomfort disturb your work? Check one: Yes ◉ No ○

_____

_____

11. Does the discomfort disturb your sleep? Check one: Yes ○ No ◉

_____

_____

12. On a scale of 1-10 with 10 being the worst pain, please rate the pain level you have today

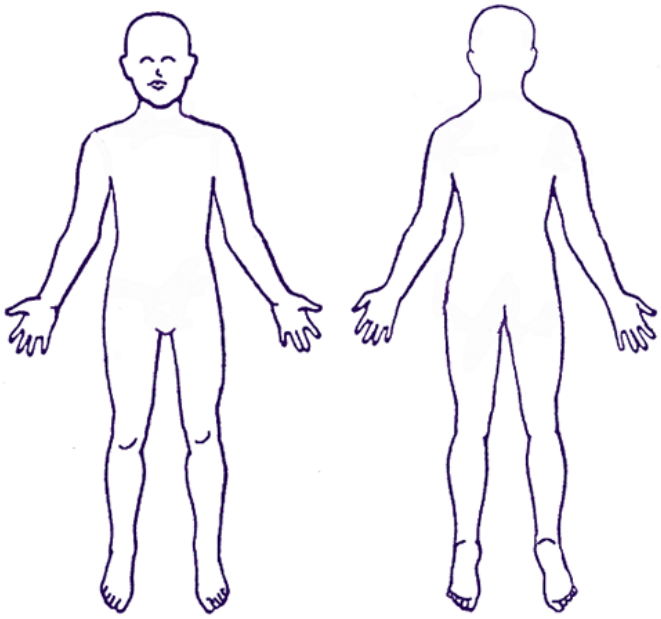
Check 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ◉ 9 ○ 10 ○

13. How would you describe the symptoms that you are experiencing? Circle all that apply

- ☐ Numbness
- ☐ Pins & Needles
- ☐ Aching
- ☐ Burning
- ☐ Stabbing
- ☐ Other:_____

Patient History Intake Form

14. On the drawing below, please indicate the painful areas on your body that we will be treating by circling them.



Please describe your symptom(s) in the space below

15. Please list any significant medical history, surgeries, etc:

16. Please describe your occupation and activities at home:

17. Are you currently or could you be pregnant? Yes ○ No ◉

18. What are your goals for therapy:

TAMARACK
PHYSICAL THERAPY

Out of Network Insurance Usage

We are an out-of-network provider, meaning we do not work with any insurance companies and are not bound by their limitations. Payment is collected at the time of service, so you won't receive any unexpected medical bills from us. We accept all major credit cards, checks, cash, Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA). Your sessions will be one-on-one, allowing us to focus entirely on your needs, something that traditional insurance models often restrict. If needed, we can provide you with a "superbill" to submit to your insurance for reimbursement, but please check with your insurance company for their specific requirements for out of network benefits.

Consider the following questions:

1. Do I have out of network benefits under my plan?
2. What is my yearly deductible for out of network services?
3. What percentage of my visit will be covered using my out of network benefits?___
4. How many visits am I allowed yearly out of network?
5. Are there any other requirements with using my out of network benefits for physical therapy (pre-authorization, etc)
6. How do I submit a superbill for reimbursement?

_____

If you have any questions, please do not hesitate to give us a call: 509-306-5105

Thank you!

t: (509) 306-5105 f: (800) 589-7414 e: davida@tamarackpt.com www.tamarackpt.com
MailingAddress:1015E2nd St#2-152CleElum,WA98922PhysicalAddress:602W.2ndStCleElum, WA 98922

Patient Demographic Information

Name: _____ DOB:_____
Age: _____

Email Address:

_____

Mailing Address:

_____

_____

Preferred Phone: _____ Secondary Phone: _____

Preferred Automated Alert for Appointment Reminders:
◯ Text ◯ Phone Call ◯ Email ◯ None

Referring Doctor Name:

_____

_____

Emergency Contact Name: _____
Relationship: _____
Phone Number: _____

If you are not the Guarantor, please fill out the following information:

Name: _____
Date of Birth: _____
Address of Guarantor:_____

_____

_____

Tamarack Physical Therapy, Inc.
602 W. 2nd St
Cle Elum, WA 98922
(509) 306-5105

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name:_____

Patient Birth Date: _____

We at Tamarack Physical Therapy are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____

Signature of patient or patient's representative/parent Date

_____

Printed name of patient or patient's representative/parent

_____

Relationship to patient