almaden physical therapy

6489 Camden Ave, Suite 109
San Jose, CA 95120
(408) 268-0600

PATIENT INTAKE FORM

Patient Information

First Name:	Last Name:	Middle Initial:	Birth Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	
Email Address:			

Chose Clinic Because/ Referred to Clinic By ☐ Dr.: ☐ Insurance Plan ☐ Family ☐ Friend

☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yelp/Google ☐ Street Sign ☐ Other:

Work Information

Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐Full Time ☐Part Time ☐Retired ☐Not Employed	

Care Provider Information

Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

Insurance Information **(Please give your insurance card to the receptionist)**

Primary Insurance Name:

Subscriber's Name (If different):	Birth Date : / /
ID. #:	Group/Policy #

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Secondary Insurance Name:

Subscriber's Name:	Birth Date : / /
ID. #:	Group/Policy #

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Auto or Work Injury Claim **(Please give your insurance card as a backup to the receptionist)**

Insurance Name: ☐ Auto: ☐ Labor & Industries:

Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

Emergency Information

Name of Local Friend or Relative (Not Living at Same Address):

Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

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MEDICAL HISTORY FORM

Patient Goals: What do you expect to get from treatment? ____

Have you had an injury due to a fall in the past year? ___Yes ___No Have you had 2+ falls in the last year? ___Yes ___No

Have you received physical, occupation, or chiropractic services at any other office for this injury? ___Yes ___No

Prescription and non-prescription medications, vitamins, or herbal medications

Name: _______________ Dose: _______________ Frequency: _______________ Reason: _______________

Name: _______________ Dose: _______________ Frequency: _______________ Reason: _______________

Name: _______________ Dose: _______________ Frequency: _______________ Reason: _______________

Date of last General Health Check-Up: _______________ **Height:** ___________ **Weight:** _______________

Surgical/Trauma History: Please list type of surgery/trauma/accident, and month/year it occurred:

____

Do you now have, or have you ever had, any of the following? (C = Current, P = Past)

C	P		C	P		C	P	
		Allergies			High Cholesterol			Hernia
		Anemia			High/Low Blood Pressure			Infectious Disease
		Anxiety			HIV/AIDS			Gout
		Arthritis/Swollen Joints			COVID			Reiter's Syndrome
		Asthma			Incontinence/Bowel Problems			Sleeping Difficulty
		Autoimmune Disorder			Kidney Problems			Numbness or Tingling
		Cancer/Chemotherapy/Radiation			Metal Implants			Weakness
		Cardiac Conditions			MRSA			Weight Gain/Loss
		Cardiac Pacemaker			Multiple Sclerosis			Energy Loss
		Chemical Dependency			Muscular Disease			Ehlers-Danlos Syndrome
		Circulation Problems			Osteoarthritis			Chronic Fatigue Syndrome
		Depression			Osteoporosis			Head/Neck Injury
		Diabetes			Parkinson's			Back Injury
		Dizzy Spells/Fainting			Rheumatoid Arthritis			Shoulder Injury
		Emphysema/Bronchitis			Seizures/Epilepsy			Elbow Injury
		Fibromyalgia			Do you smoke?			Wrist/Hand Injury
		Fractures			Speech Problems			Hip/Leg injury
		Gallbladder Problems			Strokes/TIA			Knee Injury
		Headaches			Thyroid Disease/Goiter			Ankle/Foot Injury
		Hearing Impairment			Tuberculosis			Latex/Tape Sensitivity
		Hepatitis			Vision problems			

Please list any other conditions you have, or have ever had that are not listed above that you feel could be important to your care:

____

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PATIENT HEALTH QUESTIONNAIRE-2 (PHQ-2)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1) Little interest or pleasure in doing things	0	1	2	3
2) Feeling down, depressed, or hopeless	0	1	2	3

For office coding ___0___ + _______ + _______ + ________

Total Score: _______

AGREEMENT TO PAY

I have chosen to have Almaden Physical Therapy Inc. to bill my private PPO health insurance to cover my physical therapy visits.

I have verified my insurance and believe they will pay for my therapy. However, I understand that if my insurance does not pay for any of my visits, for any reason, I am responsible to make those payments and will be billed for them.

Signature ______________________________ Date ______________________________

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INFORMED CONSENT AND PRIVACY POLICY

What is Physical Therapy? Physical therapy is a rehabilitation method that helps patients gain or regain the physical activities that they lost or that they are incapable of doing due to defects either from birth or resulting from injuries or disease. There are various methods of treatments to help one to regain and/or improve his or her physical function.

How Physical Therapy is Performed: Physical therapy is often done with the help of guided exercises. Some use additional agents such as heat or cold compress, sound waves, electricity, or mechanical devices or machine. This will depend on the issues that are needed to be addressed and the technology available for the physical therapist to utilize.

The Risks: As physical therapy intends to resolve the problem that the person is experiencing due to illness or injury, there are some risks that may arise during the course of the treatment such as pain and discomfort during the process of therapy. Stretching and twisting may cause some swelling and soreness of stiff muscles. This is normal. There are therapies that may use hot or cold compresses in order to relieve the pain during therapy. Your physician may recommend drugs in order to help you with your pain and swelling while going through the process of physical therapy.

Please take note that some can experience pain and discomfort that may reduce one's motivation to continue due to pain or lack of obvious results. It is important that the person continues with the therapy if it is too early to see the results. It would be best to discuss these matters with your physical therapist.

Expectations: There are not guaranteed expectations when one undergoes physical therapy treatment. This depends on the situation. But when one undergoes a physical therapy program, it is intended that one will be able to return to his or her prior level of functioning or develop a method to continue what was possible to be performed before the injury. When going through the program, it is important that the patient is truthful with what he or she thinks or feels. Good communication is important for the progress of the patient.

I have read and understand the information given to me and the consent to my treatment for physical therapy.

Signature ______________________________ Date ______________________________

Our legal duty: We are required by law to protect the privacy of your personal health information and will only use that information in order to treat you or assist other health providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training.

Disclosures not requiring your authorization: in the following circumstances, we may disclose your health information without your written consent: for purposes of public health and safety, to government agencies for purposes of their audits, investigations and other oversight activities, or when required by court orders, search warrants, subpoenas, and as otherwise required by law.

Your individual rights: As our patient, you have the following rights: to have access to and/or a copy of your health information, to receive an accounting of certain disclosures we have made of your health information, to request restrictions as to how your health information is used or disclosed, to request that we communicate with you in confidence, to request that we amend your health information, to receive notice of our privacy practices.

Concerns and complaints: If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer, Siddhi Shah at 408-268-0600. If you are still concerned after talking with our Privacy Officer, you may file a written complaint with the Department of Health and Human Services

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CANCELLATION AND NO SHOW POLICY

Reminder Texts and emails are provided as a courtesy. A no show cancel fee will still be applied if you did not get a reminder. Ultimately it is your responsibility to know when your appointments are scheduled.

Cancellation due to COVID symptoms or a positive COVID test: Following current health guidelines, cancellation due to COVID-like symptoms or a positive COVID test will require the cancellation of all appointments that are scheduled within 10 days of the start of symptoms.

Late cancellations:

24-hour notice is required to cancel or reschedule a one-hour appointment. Two-hour appointments require 48- hour notice. **EXCEPTION:** Monday appointments must be cancelled prior to the weekend. Voicemails left over the weekend for a Monday appointment will be counted as a late cancellation.

We understand that illnesses and family emergencies can arrive suddenly. Please notify us as soon as possible if you will be unable to make your scheduled appointment. **The first late cancellation fee per year, due to contagious illness or family emergency will be waived. Late cancellation number 2 and 3, regardless of reason, will incur a fee of $50.** Any subsequent late cancellations or no-shows will be charged the full self-pay appointment rate of $90.

No Shows:

If there is no prior communication given that you will not be able to attend your appointment, a no-show fee will be assessed. The first occurrence will incur a **$60 fee** and any subsequent occurrences will be charged the full self-pay appointment rate of $90.

Late cancellation, and no show fees will not be covered by insurance

Signature ______________________________ Date ______________________________

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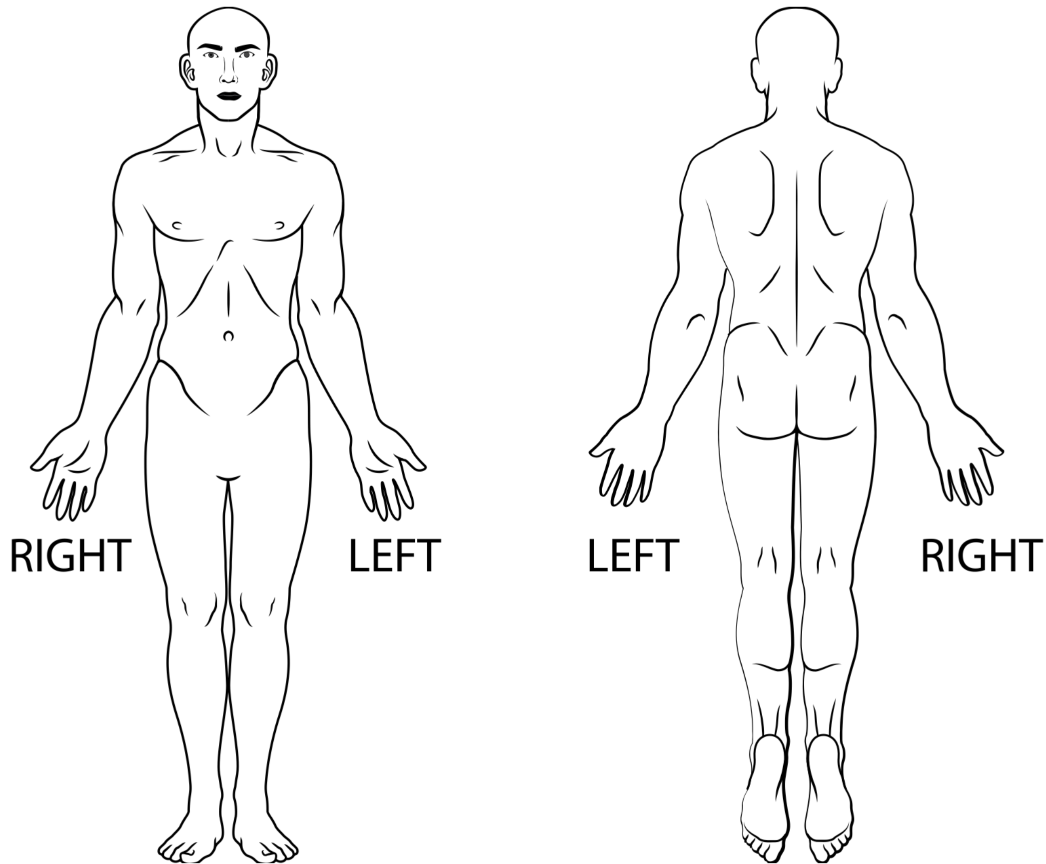
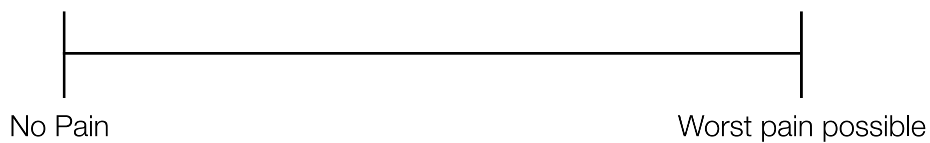
BODY PAIN DIAGRAM

On the body diagram below, please indicate where your symptoms are located at the present time.



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have felt.



No Pain Worst pain possible