NEW PATIENT INTAKE FORM

PATIENT NAME: _____ **TODAY'S DATE:** / /

DATE OF BIRTH: / / **SEX:** _____

ADDRESS: _____ **CITY/TOWN:** _____ **STATE:** **ZIP:**

MOBILE #: ( ) - **May we leave a message at this number?** YES or NO **May we send a text message to this number?** YES or NO

EMAIL ADDRESS: _____ **May we send appointment reminders and notifications via email?** YES or NO

NAME WHO REFERRED YOU TO OUR PRACTICE?: _____

EMERGENCY CONTACT: _____ **MOBILE #:** ( ) - **RELATIONSHIP:**

THIS INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE

Patient Signature: _____ **Date:** / /

CIRCLE OF WELLNESS
WOMEN'S HEALTH & CANCER CARE

781-263-0060 · circleofwellnessforwomen.com · 148 Linden Street · Suite 103 · Wellesley, MA 02482

INTAKE INFORMATION

PATIENT NAME: **DATE OF BIRTH:** / /

SEX: **AGE:** **HEIGHT:** **WEIGHT:**

MARITAL STATUS: ◯ Single ◯ Married ◯ Divorced ◯ Seperated ◯ Partnered ◯ Widowed ◯ Other

I CURRENTLY LIVE: ◯ Alone ◯ Spouse ◯ Family ◯ Friends ◯ Partner ◯ Other

DO YOU HAVE CHILDREN: ◯ YES ◯ NO Ages:

WHAT TYPE OF EXERCISE DO YOU DO AND HOW OFTEN:

WHEN WAS YOUR LAST PHYSICAL:

Primary Care Physician's Name: Phone #:

Address: Fax #:

Specialty Physician's Name: Phone #:

Address: Fax #:

Specialty Physician's Name: Phone #:

Address: Fax #:

Pharmacy Name: Phone #:

Address: Fax #:

I, by signing below, acknonwledge I have provided all my medical history information in a true manner. I understand that if I have withheld information that I may be jeaopardizing my treatment.

NAME (print): **DATE:** / /

PATIENT SIGNATURE:

SIGNATURE OF CLINICIAN INDICATING REVIEW OF ABOVE MATERIAL:

QUESTIONNAIRE

PATIENT NAME: _____ **DATE OF BIRTH:** / /

PAST MEDICAL HISTORY

(check all that apply)

- ☐ Allergies
- ☐ Alzheimers
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Bleeding Disorder
- ☐ Breast Problems
- ☐ Cataracts
- ☐ Chronic Bronchitis
- ☐ Cataracts
- ☐ Chronic Bronchitis
- ☐ Circulation of Vascular System
- ☐ Cirrhosis
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Ears
- ☐ Emphysema
- ☐ Endometriousis
- ☐ Eyes
- ☐ Fibrocystic Breast
- ☐ Fractures
- ☐ GERD
- ☐ Head Injury
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Problems
- ☐ Menningitis
- ☐ Menstrual Problems
- ☐ Nerve/Muscle Disease
- ☐ Neurological Issues
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pelvic Inflamatory Disease
- ☐ Poslycyshemica Vera
- ☐ Polymyalgia Rhuematic
- ☐ Pregnant or may be pregnant
- ☐ Prostate Disease
- ☐ Repeat Infections
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Teeth, Mouth, Jaw
- ☐ Thyroid Disease
- ☐ TIA (Transient Ischemic Attack)
- ☐ Chest Pain
- ☐ Difficulty Swallowing

ALLERGIES TO MEDICATIONS

DRUG NAME: **REACTION:**

HAVE YOU EXPERIENCED ANY:

(check all that apply)

- ☐ Difficulty Walking
- ☐ Dizziness or Loss of Consciousness
- ☐ Do you smoke
- ☐ Fatigue
- ☐ Headaches
- ☐ Joint Pain or Swelling
- ☐ Loss of Balance
- ☐ Nausea or Vomiting
- ☐ Numbness or Tingling
- ☐ Prolonged Cough or Hoarseness
- ☐ Prolonged Fevers/Chills/Sweating
- ☐ Shortness of Breath
- ☐ Take Recreational Drugs
- ☐ Urinary or Bowel Problems
- ☐ Weakness in Arms or Legs
- ☐ Weight Gain or Loss
- ☐ Pain
- ☐ Other:
- ☐ Cancer:

MEDICATION LIST

PATIENT NAME: _____ **DATE OF BIRTH:** / /

List ALL your prescribed drugs, inhalers, injections & all over-the-counter supplements such as vitamins & herbs.

DRUG / SUPPLEMENT NAME	DOSAGE	CONDITION BEING TREATED
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

Have you had surgery or other treatments for this problem or a related problem? ◯ YES ◯ NO

Have you seen another practitioner for your problem? ◯ YES ◯ NO Type of practicioner?

Have you had any of the following tests for your problem? ◯ X-Rays ◯ MRI ◯ Bone Scan ◯ CT Scan ◯ Myelogram ◯ EMG-NCV ◯ EMG-NCV ◯ Other

CIRCLE OF WELLNESS

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148 Linden Street, Suite #103 Wellesley, MA 02482 www.circleofwellnessforwomen.com Office: 781-263-0060

Updated November 1, 2023

LETTER OF UNDERSTANDING

Circle of Wellness is a solo practice dedicated to one-on-one quality care. If you must cancel your scheduled appointment, **please keep in mind that we have a strict 24-hour cancellation policy.**

Any late cancel or no show will result in the **full treatment fee** being charged. This consideration allows you the opportunity to get an appointment when none was otherwise available since we do keep a waiting list. If we can fill your appointment slot, you will not be charged.

We try to be prompt, so we ask the same from you to keep waiting to a minimum. Late-comers will be seen for the time that remains of their appointment. The initial office visit is usually 60-75 minutes. Subsequent appointments are between 45-60minutes depending on your needs and/or requests.

We are a fee for service practice, a non-participating provider of insurances which means that our patients pay us in full at time of service with a check, cash, or credit card. It is imperative that prior to your initial appointment, you contact your insurance carrier regarding your eligibility for reimbursement by calling the 800 number on the back of your insurance card (as you were asked to do when you initially called our office). We will provide you with assistance to obtain reimbursement from your insurance carrier if you are eligible for reimbursement.

Appointment Time	Cash/Check	Credit Card Payment
Initial Evaluation Office/Zoom Visit (60-75min)	$200.00	$205
Intermediate Office/zoom visit(60min)	$200.00	$205
Office/zoom visit (0-45min)	$155.00	$160

Our policies help insure our dedication to quality and timely patient care.

Patient Signature: _____ Date: _____

Signature of Responsible Party: _____ Date: _____

I have read and understand the terms of the above information.

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NO-SHOW/ CANCELLATION POLICY

Please Read Carefully

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fill other patient's scheduling needs and keep the clinic operating at its most efficient level. Due to our **one-on-one 60-minute treatments**, missed appointments are a significant disruption to, the clinic, your physical therapist, and other patients.

1. Please provide our office with 24-hour notice to charge or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for full office visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

2. We reserve your one-hour appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes. The 24-hour notice allows us to place another patient in your cancelled appointment period.

3. Certain accident claims adjusters expect regular attendance to physical therapy as a requirement of an approved treatment plan. Your treatment plan has been established by you and your practitioners to help you to get back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

4. After missing two appointments with notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

Thank you for providing our office and our patients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

Signature of Patient: _____ Date: _____

Signature of Responsible Party: _____Date: _____

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SUBJECTIVE PATIENT HISTORY

Patient Name: _____Date: _____

1. How would you describe your pain? (i.e.: sharp, dull, numbness, constant, intermittent…) _____
2. What movements/activities increase your pain/symptoms (i.e. sitting, driving, standing, walking, exercising, bending, lifting…) _____
   _____.
3. What eases your pain/symptoms? (i.e., rest, exercise, heat, ice) _____
   _____.
4. What are your current leisure/sports activities?
   _____.
5. What is your goal/purpose for coming to physical therapy?
   _____.
6. PAST MEDICAL HISTORY: Please put an "X" next to any of the following conditions that pertain to you. Describe your problem in the space provided:
   Cardiac _____Neurological_____
   Respiratory_____ Vascular_____
   Metabolic_____
   Bowel/Bladder_____
   Other: _____
7. What besides medications have you tried to help reduce your pain?
   _____
8. How would your rate your average pain intensity? Circle one.

   No Pain Moderate Worst Pain
   0 1 2 3 4 5 6 7 8 9 10

9. How would you rate the severity of your pain? This means how your pain affects your day-to-day activities (i.e. driving, caring for your family/kids, work, etc.) Circle one.

   No Effect Moderate Worst/Debilitating
   0 1 2 3 4 5 6 7 8 9 10

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10. Shade in areas you have pain. Write any comments you may have regarding your pain.

11. How much of the following things are you ABLE to do despite your pain? (i.e.: I can perform 50% of my job despite my pain).

    a. Occupation: NA 0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

    b. Daily Living: NA 0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
    (ie. Things around the house, dressing, cleaning, cooking)

    c. Recreation: NA 0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%