Discovery Therapeutic Services

Date-_____
Initial Eval: _____
Reviewed By:_____

CLIENT INTAKE FORM

Last Name: _____ First Name: _____

Date of Birth: _____ Email: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: (Home) _____ (Cell) _____ (Work)_____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Dx: _____

ICD10 _____ Auth Number: _____

Allergies/Medical Precautions:_____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) & PATIENT CONFIDENTIALITY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. The US Department of Health and Human Services (HHS) issued the HIPAA Privacy Rule to implement the requirements of HIPAA. The HIPAA Security Rule protects a subset of information covered by the Privacy Rule. The Privacy Rule standards address the use and disclosure of individuals' health information (known as *protected health information* or *PHI*) by entities subject to the Privacy Rule. These individuals and organizations are called "covered entities."

The Privacy Rule also contains standards for individuals' rights to understand and control how their health information is used. A major goal of the Privacy Rule is to make sure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high-quality healthcare, and to protect the public's health and well-being. The Privacy Rule permits important uses of information while protecting the privacy of people who seek care and healing.

The following types of individuals and organizations are subject to the Privacy Rule and considered covered entities: Healthcare Providers, Health Plans, Healthcare Clearing houses and Business Associates. Covered entities should rely on professional ethics and best judgment when considering requests for these permissive uses and disclosures. We take client confidentiality very seriously. However, in the event that a client makes a statement of harm to themselves or others, we are obligated to act on that information.

The HHS Office for Civil Rights enforces HIPAA rules, and all complaints should be reported to that office. HIPAA violations may result in civil monetary or criminal penalties. A full description of HIPPA can be found at https://www.cdc.gov

CONSENT TO TREAT & HIPPA RECEIPT

I hereby give ***Discovery Therapeutic Services, LLC*** consent to treat for my present conditions as agreed upon with my therapist/provider. I have been informed of my rights under HIPPA. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions (s) for which I seek treatment.

_____ _____ _____

Signature Printed Name Date

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www.discoverytherapeuticservices.com • info@discoverytherapeuticservices.com

Discovery Therapeutic Services

*Date-*_____
Initial Eval: _____
*Reviewed By:*_____

HOW CAN WE HELP YOU TODAY?

Last Name: _____ First Name: _____ Date of Birth: _____

Present Complaint(s):_____

Start Date: _____ Cause:_____

Current Pain Level: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

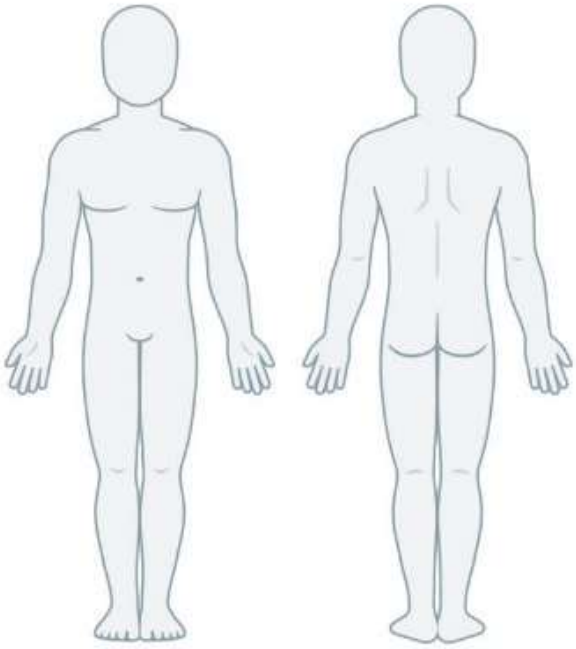
Pain Level at REST : ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating.

What makes your pain worse? _____

What makes your pain better? _____

Please mark ALL the places you are experiencing pain:

Please Elaborate:



What are your goals for physical therapy?

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MEDICAL HISTORY

Last Name: _____ First Name: _____ Date of Birth: _____

Current Health Concerns: _____

_____

_____

_____

Current Medications:

MEDICATION	*DOSE*	*MEDICATION*	*DOSE*

Drug Allergies/ Sensitivities or Reactions to Medications/ Food/ Adhesives/ Other Agents:

Please List: _____

_____

Personal Medical Conditions: Do you have any of the following?

☐ **Acid Reflux (heartburn)**	☐ **Allergies (environmental)**	☐ **Anxiety/Depression/PTSD**
☐ **Asthma**	☐ **Dizziness/Vertigo**	☐ **Autoimmune:**
☐ **Cancer: Type:**	☐ **Cholesterol Problems**	☐ **Bleeding Problems**
☐ **Cardiac Issues: A-fib/SVT**	☐ **Diabetes**	☐ **Gout**
☐ **Blood Pressure Issues**	☐ **Headaches/Migraines**	☐ **Osteopenia/Osteoporosis**
☐ **Thyroid Problems**	☐ **Blood Clots/DVT**	☐ **C-Sections**
☐ **Other**		

Please list your past surgeries/procedures:

Completed By: _____ **Date:**_____

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