Healing Hands Therapy
Intake Questionnaire

Name:		Date:
Height	Weight:	AGE:

What are you seeking treatment for: _____

When did you present symptoms start? _____

What do you think caused your symptoms? _____

Are your symptoms currently: ☐ Getting Better ☐ Getting Worse ☐ Staying about the same

My symptoms currently: ☐ Come and go ☐ Are constant ☐ Are constant, but change with activity

Have you ever had this problem before? Yes No If yes, when? _____

What treatments have you tried so far? (chiropractic, injections, etc) _____

Special tests formed / scheduled for this problem (MRI, x-ray, labs) _____

Are you on work restriction from your doctor? Yes No Are you pregnant? Yes No

Do you smoke? Yes No Do you drink alcoholic beverages? Yes No

What is the severety of your pain?

	No Pain										Worst Pain Imaginable
At its *worst*:	0	1	2	3	4	5	6	7	8	9	10
Currently:	0	1	2	3	4	5	6	7	8	9	10
At its *best*:	0	1	2	3	4	5	6	7	8	9	10

What is your ovreall average level of function?

Cannot do anything										Able to do everything
0	1	2	3	4	5	6	7	8	9	10

When are your symptoms the worst?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Exercise

When are they the best?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Exercise

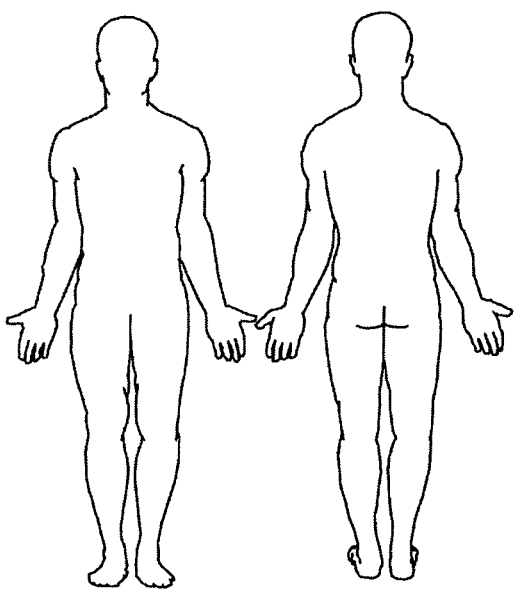
Have you RECENTLY noted any of the following?

- ☐ Pain/Tenderness
- ☐ Headaches
- ☐ Fatigue
- ☐ Muscle weakness
- ☐ Loss of balance
- ☐ Nausea/Vomiting
- ☐ Shortness of breath
- ☐ Difficulty sleeping
- ☐ Fever/Chills/Sweats
- ☐ Sudden weight loss
- ☐ Dizziness / Lightheadedness
- ☐ Heartburn/Indigestion
- ☐ Difficulty swallowing
- ☐ Vision problems
- ☐ Bowel Problems
- ☐ Bladder Problems
- ☐ Incontinence
- ☐ Discolored urine
- ☐ Difficulty starting flow
- ☐ Frequency/urgency

Please mark the areas you feel symptoms
Use the symbols to describe them:

↓ Shooting/sharp pain O Dull/aching pain

Numbness ∴ Tingling



Front Back

Aggravating Factors: (Positions or Activities)

1 _____

2 _____

3 _____

Easing Factors: (Positions or Activities)

1 _____

2 _____

3 _____

2725 Packard Suite 102 - Ann Arbor, MI 48108
Phone: 734-222-8515 - Fax: 734-222-8520

Intake Questionnaire Continued

Have you EVER been diagnosed with the following?

- ☐ Cancer
- ☐ Asthma
- ☐ Ulcers
- ☐ Epilepsy
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Pneumonia
- ☐ Depression
- ☐ Tuberculosis
- ☐ Lung problems
- ☐ Heart problems
- ☐ Liver problems
- ☐ Infertility
- ☐ Endometriosis
- ☐ High blood pressure
- ☐ Circulation problems
- ☐ Multiple sclerosis
- ☐ Thyroid problems
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Other arthritic condition
- ☐ Bladder/urinary tract infection
- ☐ Kidney problem/infection
- ☐ Sexually transmitted disease/HIV
- ☐ Pelvic inflammatory disease
- ☐ Chest pain/heart palpitations
- ☐ Chemical dependency (alcoholism)
- ☐ Bone or joint infection
- ☐ Eye problem/infection
- ☐ Fibromyalgia

Has anyone in your immediate family EVER been diagnosed with any of the following?

- ☐ Cancer
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Stroke
- ☐ Psychological
- ☐ Tuberculosis
- ☐ Abdominal Aortic Aneurysm
- ☐ Thyroid problems
- ☐ Blood clots
- ☐ Arthritis

In the past 2 weeks, have you felt down, depressed or hopeless? Yes No
Over the past 2 weeks, have you felt little interest or pleasure in doing things? Yes No
If you checked Yes, are you currently under the care of a counselor or psychiatrist? Yes No
Is this something with which you would like help? Yes Yes, but not today No

Fall History:

Have you sustained an injury as a result of a fall in the past year? Yes No
Have there been two or more falls in the last year? Yes No

Medications you are currently taking:

Name of Medication	Dosage	Frequency	Date prescribed	Why you are taking?

Have you ever taken steroid medications? Yes No
Have you ever taken blood thinning or anticoagulant medications? Yes No

Please list any surgeries:

Body Region (I.g. Right leg, back)	Surgery Procedure	Date	Any post surgery complications?

Patient Signature: _____ Date: _____

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Healing Hands Therapy Authorization Form

Thank you for choosing Healing Hands Therapy as your physical therapy provider. If you have any questions or concerns about our policies, please do not hesitate to contact us. Please read and sign this form prior to your services.

CONSENT: I consent to the physical therapy that was ordered by my physician. I understand and agree that such physical therapy services will be provided by a specialized health care provider under the direction of my physician. I acknowledge that no guarantees have been made to me as to the result of treatment and/or diagnostic procedures.

AUTHORIZATION: I authorize the release of any and all medical records concerning my treatments to my insurance company if needed for payment or reimbursement for services rendered to me. This is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) as outlined in the notice of privacy practice displayed in the treatment room. I understand that a copy will be made to me upon my request.

DIRECT PAYMENT: I authorize direct payment to Healing Hands Therapy, LTD of all benefits otherwise payable to me for care and treatment at the clinic, but not to exceed its regular charges, and I address those benefits to Healing Hands Therapy, LTD. I certify that the information provided by me is correct.

FINANCIAL RESPONSIBILITY: I agree to pay full any and all charges for services not payable or covered by my insurance carrier or other benefits. I understand that this balance is to be paid within ten (10) business days or it could result in legal action. In addition I understand that there will be a $35.00 charge for all returned checks.

INSURANCE INFORMATION: I understand that it is my responsibility to contact my insurance company if payment has not been made within 45 days of service.

This authorization is in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above financial policy. I further understand that I am financially responsible for all charges incurred for my medical treatment.

_____ _____

Patient's Signature (or authorized signature) Date

_____ _____

Printed Name of Patient Relationship to patient if not patient

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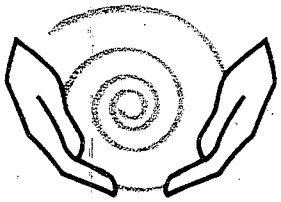

HEALING HANDS PHYSICAL THERAPY

2014 INSURANCE BILLING

DUE TO THE NEW CHANGES IN MEDICAL INSURANCE BY THE AFFORDABLE CARE ACT, YOUR INSURANCE COVERAGE MAY HAVE CHANGED OR RESET IN JANUARY. PLEASE CONTACT YOUR INSURANCE'S CUSTOMER SERVICE DEPARTMENT TO VERIFY YOUR DEDUCTIBLE, CO-PAY OR CO-INSURANCE RESPONSIBILITY. WE CANNOT VERIFY OR GUARANTEE YOUR PLANS COVERED BENEFITS. THE EXPLAINATION OF BENEFITS FROM INSURANCE & OUR BILLING STATEMENTS WILL REFLECT THE EXACT AMOUNT OF YOUR RESPONSIBILTY UNDER YOUR INSURANCE CONTRACT.

THANK YOU FOR YOUR CONTINUING CO-OPERATION.

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Sign Date

2725 PACKARD ROAD, SUITE 102, ANN ARBOR, MI 48108 PHONE (734) 222-8515 FAX (734) 222-8520

Healing Hands Therapy, LTD

2014 APPOINTMENT CANCELLATION POLICY

Cancelling less than 24 HOURS /ONE BUSINESS DAY PRIOR to you appointment may result in a **$50.00 FEE**. In the event of a Cancellation not within 24 hours/one business day,(a FIRST TIME ONLY cancellation waiver may be extended to you.) Monday appointments must be cancelled on the preceding Friday for a one business day notice. **Weekend notification for a Monday cancellation is no longer considered within a 24 hour/one business day notification**. This applies to all patients including auto claims and workers compensation cases. This will be and out of pocket administration fee due from the patient and will not be billed to your provider.

Please arrive on time for each appointment so you can take full advantage of the time that has been reserved for you. If you arrive late, your appointment may be shortened. You will be billed for the full treatment time of 45 minutes.

It is important you make every scheduled appointment. When you miss an appointment, it:

1. AFFECTS YOUR TREATMENT PLAN, PROGRESS & FUTURE SCHEDULING
2. AFFECTS THE THERAPISTS SCHEDULE & ADMINISTRATION OF YOUR CARE
3. PREVENTS US FROM SEEING ANOTHER PATIENT

I have read and understand the Healing Hands Therapy 2014 Appointment Cancellation Policy

_____
Patient Signature (or authorized signature)

_____
Printed Name of Patient

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