NEW PATIENT PI INTAKE FORM

NAME: _____ M / F SS#:_____

ADDRESS: _____CITY: _____ STATE: _____ZIP: _____

HOME PH.: _____ CELL PH.: _____ WORK PH.:_____

DATE OF INJURY:_____DATE OF BIRTH:_____AGE:_____

WHAT TYPE OF ACCIDENT WERE YOU INVOLVED IN? M V A or PI

DO YOU HAVE HEALTH INSURANCE? Yes No

WHO IS THE CARRIER (bring insurance card to appointment):_____

DO YOU HAVE CAR INSURANCE? Yes No

WHO IS THE CARRIER?:_____ DO YOU HAVE MED-PAY? Yes No
(bring insurance card)

NAME OF PRIMARY CARE PHYSICIAN:_____ PH#:_____

PLEASE DESCRIBE HOW ACCIDENT HAPPENED:_____
_____
_____
_____
_____
_____

WHAT STREET WERE YOU TRAVELING ON?:_____

IF AN MOTOR VEHICLE ACCIDENT, WERE YOU THE driver front seat passenger
back seat passenger (behind the driver? In the middle? On passenger's side?)

CAR YOU WERE IN: YEAR_____ MAKE_____ MODEL_____

OTHER VEHICLE: YEAR_____ MAKE_____ MODEL_____

WERE YOU: HIT HEAD-ON SIDESWIPED REAR-ENDED OTHER:

DID THE AIR BAGS DEPLOY? Yes No

_____

PATIENT'S NAME

WERE YOU JOLTED: SIDEWAYS BACKWARD FORWARD

DID YOU HAVE IMMEDIATE PAIN? Yes No
WHERE?_____

*DID YOU EXPERIENCE DIZZINESS, HEADACHES, NAUSEA, or VISION DISTURBANCES?

DID YOU HIT YOUR HEAD OR ANY PART OF YOUR BODY ON THE CAR'S INTERIOR?
_____

WHO RESPONDED TO THE SCENE? POLICE AMBULANCE FIRE DEPARTMENT?

DID YOU GO TO THE: E R? URGENT CARE? PRIMARY CARE PHYSICIAN?

WHERE?_____

TRANSPORTED BY AMBULANCE? Yes No WERE X-RAYS TAKEN? Yes No

OF WHAT?_____

WHAT SYMPTOMS DID YOU COMPLAIN OF IN THE E R /UC/PRIMARY CARE PHYSICIAN?:
_____
_____
_____

WERE YOU GIVEN AN INJECTION OR MEDICATIONS WHILE IN THE E R? Yes No
WHAT?_____

WERE YOU PRESCRIBED MEDICATIONS TO TAKE AT HOME? Yes No

WHAT?_____

DID YOU MISS WORK OR SCHOOL? Yes No HOW MANY DAYS:_____

LIST DATES_____

WHAT HAVE YOU BEEN DOING FOR THE PAIN SINCE THE ACCIDENT?
_____
DID YOU USE ANY HOME REMEDIES SUCH AS SOAKING IN A WARM TUB, USING OVER-THE-COUNTER MEDICATIONS, USING ICY-HOT RUB OR BEN GAY, ICE PACKS, OR HEAT WRAPS? _____

_____

PATIENT'S NAME

WHAT INJURIES OR SYMPTOMS ARE YOU COMPLAINING OF NOW?_____

_____

_____

SINCE THE ACCIDENT, HAVE YOU EXPERIENCED: (circle) DIZZINESS, NAUSEA, HEADACHES, RESTRICTED MOVEMENTS

IS THE PAIN: MILD - MODERATE - SEVERE - RADIATING to _____
WORSE AT NIGHT OR DURING THE DAY - CONSTANT or INTERMITTENT

DO YOU HAVE NUMBNESS or TINGLING? _____
OTHER SYMPTOMS:_____

*DO YOU (OR DID YOU) HAVE ANY BRUISES? _____

DOES YOUR PAIN INCREASE WHEN YOU:
DRIVE - ENTER OR EXIT A CAR - SIT - WALK- LOOK OVER YOUR SHOULDER - VACUUM- LIFT - BEND - COOK - REMOVE WET CLOTHES FROM THE WASHING MACHINE- PLACE WET CLOTHES IN THE DRYER - GO UP AND DOWN STAIRS - GET DRESSED - PULL TOPS OVER YOUR HEAD - DO YARD WORK OR SHOVEL SNOW - SLEEP - RAISE ARMS TO WASH OR COMB HAIR - GET IN OR OUT OF BED - CARE FOR CHILDREN PERFORM ACTIVITIES OF DAILY LIVING - OTHER:_____

PAST MEDICAL/SURGICAL HISTORY:_____

_____

(circle yes or no)_____

-GI BLEEDING Yes No -STOMACH ULCERS Yes No -KIDNEY PROBLEMS Yes No
-DIABETES Yes No -HIGH BLOOD PRESSURE Yes No -HEART PROBLEMS Yes No
-PACEMAKER Yes No -FOREIGN METAL Yes No -DRUG ADDICTION Yes No
-HIV/AIDS Yes No -HEPATITIS _____Yes No -PREGNANT Yes No

ALLERGIES?: _____

CURRENT MEDICATIONS:_____

_____

PREVIOUS INJURIES:_____

_____

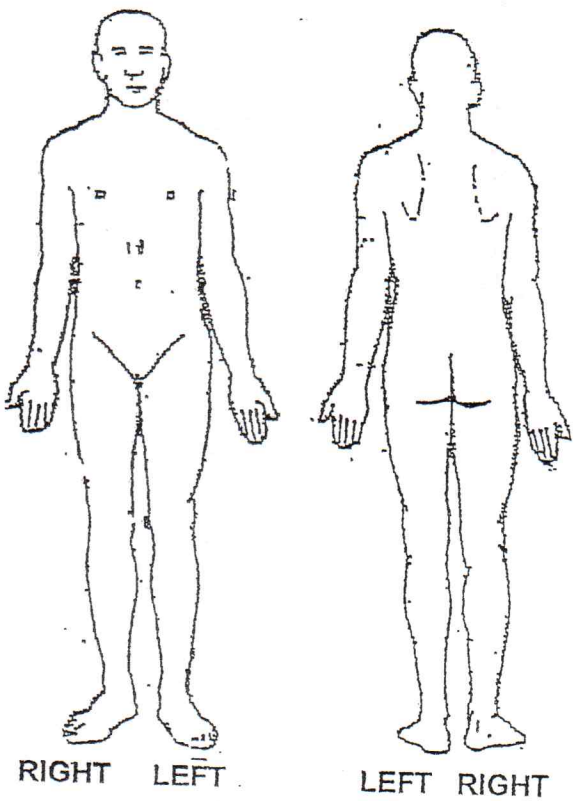
Today's Date_____

INITIAL VISIT FORM

Name_____

PAIN DRAWING

Carefully shade or mark the areas where you feel any pain on the drawing below



This form will allow Cleveland Therapy to obtain your medical records relating to this injury, from the hospital emergency room, urgent care center of family physician.

AUTHORITY TO RELEASE MEDICAL AND/OR HOSPITAL RECORDS

Patient Name_____ Date of Birth_____

Date of Admission on or about_____

You are hereby authorized and directed to permit this therapy center to examine, photostat, and copy any and all reports and records pertaining to my treatment rendered at your hospital, urgent care center, and/or physician's office on or around the above date.

Please furnish the undersigned with a copy of the records indicated below:

_____ Emergency Room Records

_____ Urgent Care Records

_____ Physician Progress Visit

_____ X-ray, CT Scan, MRI Reports

_____ Consultation

_____ Other _____

Cleveland Therapy's physicians would like these medical records faxed to the below circled location.

1. Cleveland Therapy - Brainard
   Brainard Place Medical Building
   29001 Cedar Road, Suite 309
   Lyndhurst, Ohio 44124-4041
   Fax 216-721-4441
   Phone 216-721-4955

2. Cleveland Therapy - West
   West Valley Medical Building
   20455 Lorain Road, Suite 102
   Fairview Park, Ohio 44126-3529
   Fax 440-734-4184
   Phone 440-734-4084

3. Cleveland Therapy – Parma
   York Executive Building II
   6325 York Road, Suite 203
   Parma Heights, Ohio 44130-3030
   Fax 440-842-1796
   Phone 440-842-1229

The patient has the right to revoke this request within 7 business days, by contacting Cleveland Therapy either by phone or letter. This should be directed to where the medical records are stored.

20455 Lorain Road, Suite 102
Fairview Park, Ohio 44126
440-734-4084

A COPY OF THIS RELEASE AND AUTHORIZATION SHALL SERVE AS THE ORIGINAL

Signature_____ Date_____

This form allows Cleveland Therapy to forward your records to your insurance carrier, local medical doctor, and/or attorney.

NAME_____

SSN#_____

DATE OF INJURY_____

I hereby authorize and permit this therapy center to examine, or Photostat all reports, itemized patient bills and records including Emergency Room and hospital reports, police reports, x-ray reports, and other reports pertaining to my treatment rendered in regard to the above date of injury. The records can then be forwarded to my insurance carrier, local medical doctor, and or attorney at the completion of my treatment.

SIGNATURE_____ DATE_____

MEDICAL RECORDS FASCIMILE TRANSMISSION AUTHORIZATION

I, _____, understand that you will be transmitting my medical records electronically, and authorize you to do so. If they are received by another party in error, I absolve this therapy center of any and all liability relating to such submission of said records.

A COPY OF THIS RELEASE AND AUTHORIZATION SHALL SERVE AS THE ORIGINAL

SIGNATURE_____DATE_____

This allows Cleveland Therapy to be paid for your medical treatment by your attorney.

ASSIGNMENT FOR PAYMENT OF PROVIDER'S FEE

Date of Accident: _____

Name: _____

I do hereby assign to this therapy center the amount due for services and goods rendered to me, from my recovery resulting from a claim or law suit arising from my accident.

I hereby direct my attorney to honor this assignment as a lien against any funds that might be due me as a result of such claim or law suit, and my attorney is hereby authorized and directed to issue payment directly, without any further approval by me.

This assignment is irrevocable without the approval of this therapy center.

The execution does not make the fee due to the therapy center contingent upon my securing a recovery in any loss or claim that I may have against any party or insurance company, nor does this assignment preclude this therapy center from demanding payment at any time after service is rendered.

Signed: _____

Date: _____

/assign1