Roper Physical Therapy & Myofascial Release
301 E. Tremont Avenue, Suite B
Charlotte, NC 28203
(P) 980.298.6706 (F) 980.2327.0722
http://RoperPT.com

PHYSICAL THERAPY INTAKE FORM

Name_____

Mailing Address_____City_____ State _____ Zip _____

Home Phone_____ Cell Phone _____

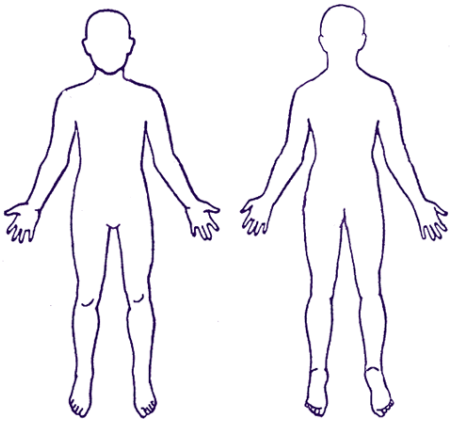
Email Address _____ Employer: _____

Emergency Contact _____ Emergency Phone _____

Referring Physician/ Person _____

Date of Birth_____/_____/_____ Medicare Recipient? YES or NO *** If yes, please see below.**

**Roper Physical Therapy is a small, private practice. We are not a Medicare provider; therefore, insurance claims from our practice will not be accepted as we do not meet Medicare requirements. A waiver must be signed stating that you understand our Medicare policy prior to treatment*



Please briefly describe your symptoms:

_____

_____

_____

_____

Nature of pain/symptoms. Please check all that apply.

- ☐ Sharp
- ☐ Throbbing
- ☐ Dull
- ☐ Aching
- ☐ Constant
- ☐ Periodic
- ☐ Occasional
- ☐ Other (Please describe below)

_____

Rate the intensity of your pain at its worst :

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

When did you first notice symptoms? _____

Length of time experiencing pain? _____

Are there any other health issues that we need to be aware of? (If yes, please describe below)

_____

Surgeries (Type/Date)_____ Tests (MRI, CAT, X-Rays) _____

Please list any prescription medications, including nutritional supplements you are currently taking:

_____

What treatments have you received regarding your current diagnosis?

- ☐ Physical Therapy
- ☐ Chiropractor
- ☐ Massage
- ☐ Acupuncture
- ☐ Dry-needling
- ☐ Other

What is your current level of activity? Please list exercise/sports (type, frequency, duration)

_____

Consent to be treated: _____ Date: _____

(Signature Required)

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HIPAA Privacy Notice Acknowledgement Form

We are required by law to provide you with our Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature_____ Date_____
(Patient or Authorized Representative)

Relationship to Patient if Authorized Representative: _____

Reason patient is unable or unwilling to sign: _____

Once you have filled out and signed this document, please

Email to : FrontDesk@RoperPT.com

or

FAX to 980.232.0722