Kleinpeter
PHYSICAL THERAPY
EXPERT CARE WITH A PERSONAL TOUCH.

Today is your first appointment at our clinic, and I hope your first experience meets or exceeds your expectations.

As Executive Director, I want you to know that your feedback is very important to me. Please save this cover letter so that you can contact me directly with any suggestions, questions, concerns, or other comments.

Learning from your experience is an important part of our effort to make your experience here as good as possible.

Thank you for choosing Kleinpeter PT. Please feel free to contact me at karl@kleinpeterpt.com or call (225) 658-7751.

Sincerely,

Karl Kleinpeter, PT, DPT
Executive Director

Initial Physical Therapy Evaluation Intake Form

Demographics

Name: _____ **Date form completed:** _____

Address: _____ **City:** _____ **State:** ___ **Zip:** _____

Phone number: _____ **Email address:** _____

Date of birth: _____ **Age:** _____ years **Social Security Number:** _____

Height: ___ feet ___ inches **Weight:** _____ lb **Sex**: ☐ Male ☐ Female

Spouse's Name (if applicable): _____

Spouse's Date of birth: _____ *Spouse's phone number:* _____

Spouse's Employer (if insurance is through spouse): _____

Occupation/employment status:
☐ Retired
☐ Full-time
☐ Part-time
☐ Unemployed

Employer: _____

Job Title: _____

Primary care health care provider: _____

Have you received physical therapy at home in the last 30 days? If yes, for what condition? _____

Emergency contact name: _____ **Phone number:** _____

Are you seeking treatment for a condition related to an accident or injury? ☐ Yes ☐ No
If yes, what type? ☐ Auto ☐ Work ☐ Other Date of Injury: _____

Responsible Party: ☐ Workman's Comp ☐ Attorney ☐ Insurance: _____

How did you hear about us? ☐ Physician ☐ Attorney ☐ Social Media ☐ Friend/Family ☐ Google/Internet

Signature of Patient or Guardian: _____

My signature below indicates that I have been given the Notice of Privacy Practices for Kleinpeter Physical Therapy, LLC. I recognize that outside of purposes of treatment, for payment, for certain healthcare operations or as permitted or required by law, I must give my written authorization to Kleinpeter Physical Therapy, LLC to release any of my protected healthcare information.

Signature of Patient or Authorized Representative: _____

Printed Name: _____ **Date**: _____

Patient Health Information

Reason for Visit

Which body part is your primary concern today? _____

Current pain level, 0-10 (0=best, 10=worst): _____

Nature of pain (check all that apply): □ Dull and achy □ Shooting □ Sharp and stabbing □ Burning
□ Pins and needles □ Numb □ Deep □ Constant

What worsens your pain? (check all that apply)
□ Reaching back □ Laying flat □ Getting out of chair / bed □ Bending forward □ Lifting
□ Twisting □ Standing □ Raising arm overhead □ Looking up/down □ Walking
□ Sitting □ Driving □ Carrying items □ Pushing/pulling □ Leaning back

Do any of the following alleviate your pain? (check all that apply)
□ Ice □ Heat □ Pain medicine □ Laying flat □ Bending forward □ Leaning back □ Resting
□ Rest □ Sleep □ Stretching □ Walking □ Exercise □ Avoiding activity □ Massage
□ Nothing reduces my pain

Is this a reoccurrence of a prior injury? □ yes □ no

Have you had imaging (i.e., x-ray, MRI, CT, etc.) for this condition? □ yes □ no

Have you had surgery for the primary condition you are being seen for? □ yes □ no

If applicable, date of surgery? _____ Surgeon: _____

If applicable, which body part is your secondary concern? _____

Current pain level, rated 0-10: _____ **Pain Description:** _____

What worsens this pain? _____

Is there something that alleviates this pain? _____

How much is your daily routine affected by your current physical condition?
□ Not affected □ Affected, but I cope □ Affected 1 day/wk □ Affected 2 days/wk □ Affected 3 days/wk □ Affected, but I cope

Does your current physical condition impact your ability to do your job or attend school?
□ Not applicable / retired □ Prevents working □ Can only work part time
□ Able to work (great difficulty) □ Able to work (minor difficulty) □ Not affected

Have you been bothered by feeling down, depressed, or hopeless because of your current condition?
□ yes □ no

In the past two weeks, have you been bothered by having little interest or pleasure in doing things?
□ yes □ no

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Patient Health Information

Medical History

Do you have any of the following medical conditions?			
Current or past history of cancer	☐ **yes**	☐ **no**	Type: _____
Diabetes or high blood pressure	☐ **yes**	☐ **no**	Type 1 or Type 2? ___
Hypoglycemia or low blood pressure	☐ **yes**	☐ **no**	
Heart attack / heart disease	☐ **yes**	☐ **no**	
Blood clot	☐ **yes**	☐ **no**	
Pacemaker, implantable defibrillator	☐ **yes**	☐ **no**	
Lung problems (COPD, asthma, shortness of breath)	☐ **yes**	☐ **no**	
Stroke	☐ **yes**	☐ **no**	Date: _____
Neurological disease (Multiple Sclerosis, Myasthenia Gravis, Parkinson's, Guillain-Barre, Cerebral Palsy)	☐ **yes**	☐ **no**	
Concussion	☐ **yes**	☐ **no**	Date: _____
Mental health disorder (bipolar, depression)	☐ **yes**	☐ **no**	
Seizures, epilepsy	☐ **yes**	☐ **no**	
Dizziness, fainting, or vertigo	☐ **yes**	☐ **no**	
Stomach problems, ulcers	☐ **yes**	☐ **no**	
Thyroid abnormalities	☐ **yes**	☐ **no**	
Kidney disease	☐ **yes**	☐ **no**	**Dialysis?** ☐ yes ☐ no
Urinary incontinence or retention (within the last year)	☐ **yes**	☐ **no**	
Bowel abnormalities (including constipation or leakage)	☐ **yes**	☐ **no**	
Sexual or pelvic health dysfunction	☐ **yes**	☐ **no**	
Pregnancy (current)	☐ **yes**	☐ **no**	
Arthritis (osteoarthritis or rheumatoid arthritis)	☐ **yes**	☐ **no**	
Joint replacement	☐ **yes**	☐ **no**	Location(s): _____
Osteoporosis	☐ **yes**	☐ **no**	
Gout	☐ **yes**	☐ **no**	
Lupus	☐ **yes**	☐ **no**	
Lymphedema	☐ **yes**	☐ **no**	
Allergies	☐ **yes**	☐ **no**	Type: _____
	Do you have a latex allergy? ☐ yes ☐ no		
Skin irritation (including cellulitis)	☐ **yes**	☐ **no**	
Is there any other information about your health or medical history you would like to share?			

Fall History

Do you have any balance concerns or instability when walking?	☐ **yes** ☐ **no**	
Do you use an assistive device? ☐ cane ☐ walker ☐ wheelchair ☐ crutches ☐ no assistive device		
Have you experienced any falls within the last year?	☐ **yes** ☐ **no**	How many falls? _____
		Were you injured? _____

Social Habits

Do you currently smoke? (i.e., cigarettes, cigars, chewing tobacco, vaping)	☐ **yes**	☐ **no**
Do you exercise regularly? ☐ **yes**	☐ **no**	If yes, how often? _____

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Medications		
Please list current medications below or provide front desk with list ☐ front desk was provided with copy of medication list		
Medication:	**Dose:**	**Frequency:**

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Appointment Cancellation Policy

Welcome and thank you for choosing Kleinpeter physical Therapy! The rehabilitation program that you are starting has been designed specifically for you. Our professional staff is committed to working with you to achieve your goals and to help you return to a fully productive and independent lifestyle.

The rehabilitation program takes a great degree of discipline and commitment to achieve your goals. Consistent and timely attendance to your scheduled therapy sessions is vital to accomplishing your desired results and returning you to your daily activities as quickly as possible. Missing appointment may adversely affect your recovery and result in a longer duration of care, poor outcomes, and a delayed return to your daily activities.

Please keep in mind our cancellation policy is as follows:

- **You must give 24-hour notice in the event that you need to reschedule your appointment. This will allow us the opportunity to schedule appointments for other patients.**
- A “no show”, “no call”, or missed / cancelled appointment without proper 24-hr notification may be assessed for a $25 fee.
    - This fee is not billable to your insurance.
- 3 cancellations or “no show” appointments may result in immediate discontinuation of services or notification to your referring physician of discharge due to noncompliance. A new prescription may be required to resume therapy.
- If you are more than 15 minutes late for your scheduled appointment, we reserve the right to cancel and reschedule or shorten the length of the visit.
- As a courtesy, we send reminder texts or calls for appointments one day in advance. Please note that if a reminder is not received, the cancellation policy remains in effect.

If you have questions regarding this policy, please let our staff know, and we will gladly clarify any questions you have. If desired, a copy of this policy will be provided to you; please let the front desk know this intention.

Please sign and date below your acknowledgement:
I have read and understand the Appointment Cancellation Policy, and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

Printed Name of Patient: _____

Signature of Patient: _____ Date: _____

For front desk use:

Account # _____ *Patient was provided with copy of policy: ☐ yes ☐ no*