TKO PHYSICAL THERAPY, PLLC
Boston, Massachusetts
720-335-7889

Patient Intake Form

Name:_____ Date:_____

Preferred Pronoun	Preferred Name (if different from given name)	Date of Birth

Phone	Email

Street Address	City	State	Zip Code

Occupation

Emergency Contact Name	Relationship	Phone Number

Primary Care Doctor	Phone Number

Do you now have or have had any of the following?

	Pacemaker		DVT (Deep Vein Thrombosis)
	Metal Implants		Arthritis
	High Blood Pressure		Osteopenia
	Diabetes		Osteoporosis
	Heart Disease		Cancer/Tumor
	Heart Attack		Recent Weight Loss / Gain
	Vascular Disease		Current Infections
	Stroke		Tuberculosis
	Asthma		Hepatitis
	Punctured Lung		Skin Conditions
	Shortness of Breath		Headaches
	Chronic Cough		Head Injury / Concussion
	Fainting Spells		Hernia
	Bone Fractures		Bowel/Bladder Problems
	Previous Surgeries		Thyroid Problems
	History of Abuse		Substance Abuse
	Allergies		Pregnancy (__Past __Present)
			Other

If you checked 'other,' please describe:

Please List current medications and supplements below:

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Current Injury / Complaint: _____

Date of Onset: ___ / ___ / _____

How did this injury occur:

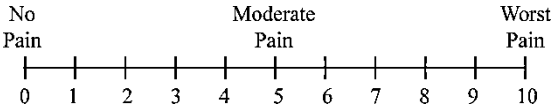
For this injury, have you had any surgeries or received care from a medical professional? Yes___ No___

If so, describe treatment type and duration:

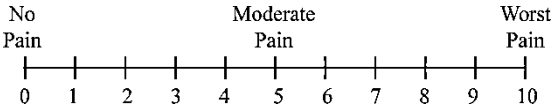
Current exercise / training regime and upcoming events / competition:

In the past 7 days, rate you pain on a 0-10 scale:

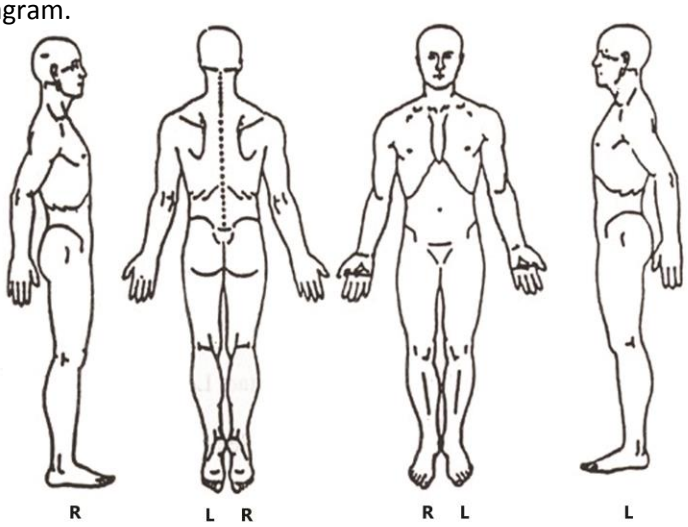
At Best:



At Worst:



Mark the location of your pain on the body diagram.



Describe the nature of your pain:

___ Getting Better
___Staying the same
___Getting Worse

Sore	Constant
Achy	Intermittent
Burning	Shooting
Numbness	Radiating
Tingling	Throbbing

I've completed the information above to the best of my knowledge.

Signature:_____ Date:_____

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Patient Agreement

Please initial next to each statement.

___ I acknowledge that TKO Physical Therapy may disclose protected health information to the head coach at _____(state your gym) or _____your medical doctor (MD) for the purpose of maintaining a safe training environment relative to the issue for which I'm being treated.

___ I acknowledge that all the information provided is correct and up to date.

___ I acknowledge that I am responsible to settle any outstanding balance due and owing TKO Physical Therapy at the time of this Agreement.

___ **Consent to Treat.**
I consent to receive outpatient rehabilitation physical therapy services and any ancillary services that are deemed medically necessary or appropriate by my physical therapist. I am aware that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or treatment results from the rehabilitation therapy.

___ **Consent to Record.**
In conjunction with my care, I consent to allow the use of filming devices such as a camera or cell phone for the purposes of enhancing my care. I consent to the transmittal of such filming device images or video to TKO Physical Therapy through email or text. I acknowledge that such film and related images will only be used or disclosed for treatment purposes, and that TKO Physical Therapy will not further use or disclose such film or images for any other purpose without my authorization or consent. **If you do not consent to this, please strike this section.**

___ **Cancellation Policy.**
For cancellations, contact TKO PT by email taekyungphysicaltherapy@gmail.com or by phone 720-335-7889 within 24 hours of the appointment. For late cancellations or missed visits, a $25.00 fee will result. This fee will be paid at the patient's next scheduled appointment. Insurance does not cover these fees.

___ **Financial Responsibility.**
I agree to pay TKO Physical Therapy all amounts that are due and owing for services provided on my behalf. In the event that this account is referred to a collection agency or attorney, the undersigned agrees to pay all reasonable costs of collection including, but not limited to, reasonable attorney's fees.

___ **HIPPA Privacy Rule.**
In compliance with the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule, I understand that TKO Physical Therapy will not disclose my protected health information (PHI) without my explicit authorization, except as required or permitted by law for the purposes payment, treatment, and health care operations. Furthermore, TKO Physical Therapy will limit the use, disclosure of, and requests for PHI to the minimum amount necessary to accomplish the intended purpose.

Signature:_____ Date:_____