OPTIMUM
WELLNESS CENTERS

2724 5th St W, Suite A
Lehigh Acres, FL 33971

3820 Colonial Blvd, Suite 201
Fort Myers, FL 33966

870 W. Hickpochee Ave.
LaBelle, FL 33935

(239) 303-1501
(239) 931-7802
admin@optimumwellnesscenters.com
optimumwellnesscenters.com

Patient Intake Form

Today's Date:

IMPORTANT INSTRUCTIONS:
1) SAVE the blank form to your computer and CLOSE. 2) Open the saved form in Adobe Acrobat Reader (free software). 3) Type in your information and SAVE. Print a copy to bring with you or email to admin@optimumwellnesscenters.com.

Name: Date of Birth:

Patient's Social Security No.:

Address:

City, State, Zip Code:

Northern Address:

City, State, Zip Code:

Home Phone: Work Phone:

Cell Phone: Email:

Sex: M ☐ F ☐ Age: Marital Status:

If insurance coverage is under your spouse, please list the following information:

Spouse's Name: Date of Birth:

ATTORNEY:
Do you have an attorney representing you regarding your illness or injury? Yes ☐ No ☐

Attorney's Name:

Attorney's Address:

Attorney Phone:

ASSIGNMENT AND RELEASE:

I, the undersigned, certify that I (or my dependent) have insurance coverage with and assign directly with Optimum Wellness Center, all insurance benefits. Otherwise services rendered will be payable by me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Optimum Wellness Centers to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

1. X _____ Today's Date: _____

Responsible Party Signature

I understand that, if for any reason, this account is placed with a collection agency; the collection fee will be added to the account!

2. X _____ Today's Date: _____

Responsible Party Signature

AUTHORIZATION AND CONSENT:

I, the undersigned, authorize and consent to treatment from Optimum Wellness Centers for treatments that were developed by my physician/therapist per my Plan of Care.

3. X _____ Today's Date: _____

Responsible Party Signature

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS:

I consent to OPTIMUM WELLNESS CENTERS using and disclosing my protected health information to carry out treatment, payment, or healthcare operations. I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent. I understand that OPTIMUM WELLNESS CENTERS reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written request addressed to: Optimum Wellness Centers, 2724 5th St W, Suite A, 33971.

I understand that I have the right to restrict how OPTIMUM WELLNESS CENTERS uses or discloses my protected health information to carry out treatment, and that OPTIMUM WELLNESS CENTERS is not required to agree to the restrictions and that OPTIMUM WELLNESS CENTERS is bound by restrictions to which it agrees. I request the following restrictions to how my health information is used or disclosed:

I have the right to revoke this consent by notifying OPTIMUM WELLNESS CENTERS in writing, except that to the extent that OPTIMUM WELLNESS CENTERS has taken action in reliance on my consent.

4. X _____ Date: _____

Signature of patient or patient's representative

_____

Print name of patient or patient's representative

OPTIMUM WELLNESS CENTERS PATIENT RIGHTS AND RESPONSIBILITIES

1. A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
2. A patient has the right to a prompt and reasonable response to questions and requests.
3. A patient has the right to know who is providing medical services and who is responsible for his or her care.
4. A patient has the right to know what rule and regulations apply to his or her conduct.
5. A patient has the right to be given by the health care provider information concerning planned course of treatment, alternatives, risk, and prognosis.
6. A patient has the right to refuse treatment, except as otherwise provided by law.
7. A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider accepts the Medicare assignment rate.
8. A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges.
9. A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
10. A patient has the right to express grievances regarding any violations of his or her rights, as stated in Florida law, through and grievance procedure to the health care provider.
11. A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
12. A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
13. A patient is responsible for following the treatment plan recommended by the health care provider.
14. A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, must notify the health care provider.
15. A patient is responsible for his or her actions if he or she refused treatment or does not follow the health care provider's instructions.

5. X _____ Date: _____

Patient's Signature

Patient Medical Information

Date of Injury or Onset:

Please check if you are: Right Handed ☐ Left Handed ☐

Medicare physical therapy only: Have you had physical therapy elsewhere since January 1st of this year?.
Yes ☐ No ☐ If so where? How many visits?

Is this injury related to a motor vehicle accident (MVA)? Yes ☐ No ☐

Is this a Worker's Comp injury? Yes ☐ No ☐

Are you receiving any Home Health Services? Yes ☐ No ☐

What is your chief complaint?

How did this problem occur?

Have you had any treatment for this problem/condition prior to today? If so, please list:

Are you taking any prescribed medications regarding this injury/condition? If so, please list:

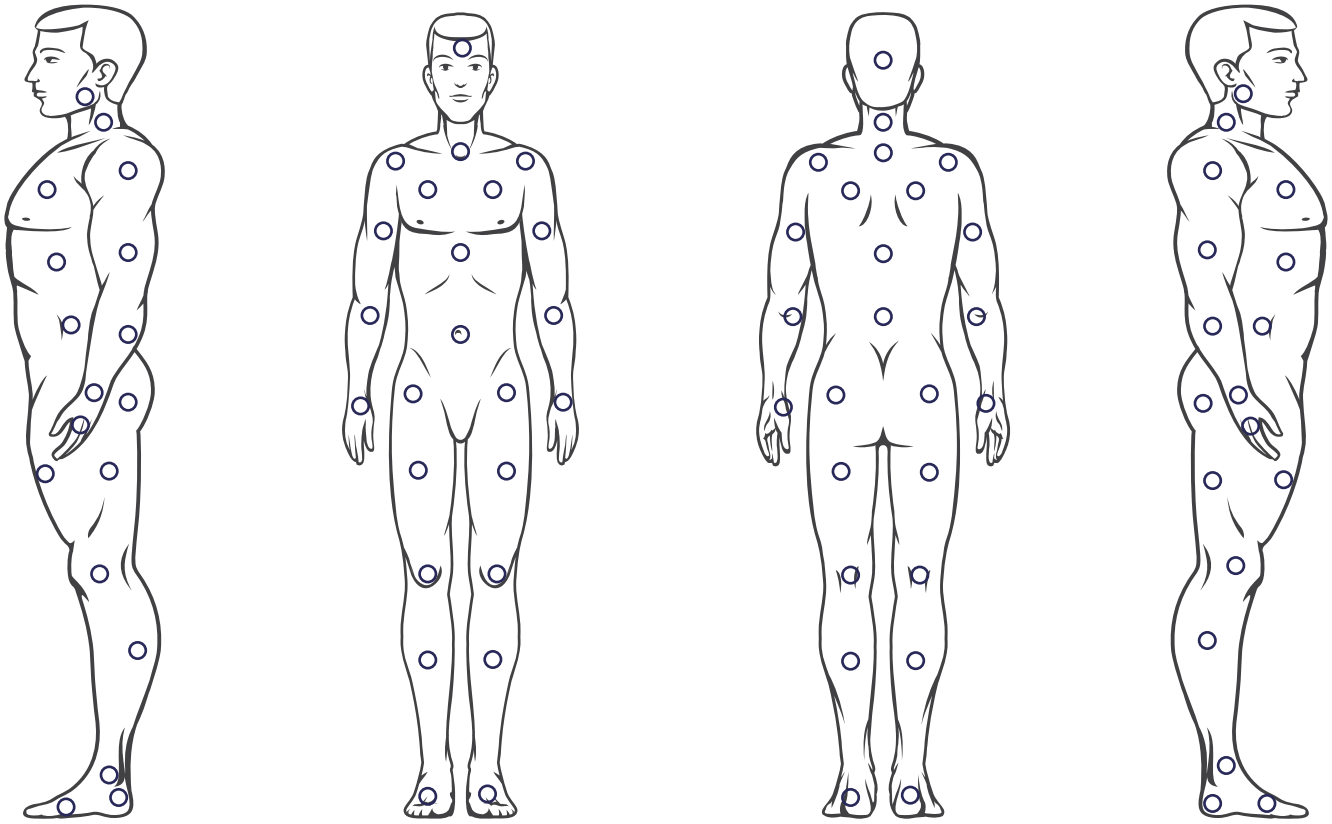
Have you had any of the following diagnostic tests?

MRI ☐ X-RAY ☐ CT SCAN ☐ BONE SCAN ☐ OTHER

Have you had an injury to this area before? Yes ☐ No ☐ If yes, please explain:

DESCRIBE YOUR PAIN:

Please mark the drawings where you feel pain:



Rate your **overall** pain on the McGill Pain Scale (0-10): 0 = no pain; 10= severe pain:

Where is your CURRENT Pain Scale?

Where is your LEAST Pain Scale?

Where is your MOST Pain Scale?

How often do you have this pain?

When are the symptoms/pain worse?

Morning ☐ Afternoon ☐ Evening ☐ Inconsistent ☐ Other (describe)

What makes your symptoms/pain lessen?

Sleep ☐ Sitting ☐ Bending: Forward ☐ Backward ☐ Rest ☐

Limb Elevation ☐ Arm down by side ☐ Medication ☐ Muscle Cream ☐

Ice ☐ Heat ☐ Other

What makes your symptoms/pain worse?

Sitting ☐ Standing ☐ Right Side-lying ☐ Left Side-Lying ☐

Squatting ☐ Bending: Forward ☐ Backward ☐ Side-bending ☐

Reaching Overhead ☐ Reaching Behind Head ☐ Walking ☐ Other ☐

Type of Pain:

Dull ☐ Sharp ☐ Sore ☐ Throbbing ☐ Constant ☐ Aching ☐

Intermittent (comes and goes) ☐ Burning ☐ Numbness ☐ Radiating ☐

Shooting ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Other ☐

Medical History and Musculoskeletal Systems Review

Height: ☐ Weight: ☐

Has this problem affected your daily life or routine? If so, please briefly explain:

☐

Please list any prescription medications you are taking:

☐

Musculoskeletal System:

	Yes	No
Arthritis	☐	☐
Metal Implants	☐	☐
Sprains/Strains	☐	☐
Osteoporosis	☐	☐
Joint Replacement	☐	☐
Joint Pain	☐	☐
Fibromyalgia	☐	☐

Neurological System:

	Yes	No
Parkinson's Disease	☐	☐
Multiple Sclerosis	☐	☐
Seizures	☐	☐
Emotional/Depression	☐	☐
Stroke	☐	☐
Head Trauma	☐	☐
Tremors	☐	☐
Hearing/Visual disturbances	☐	☐
Confusion	☐	☐

Cardiovascular System:

	Yes	No
Pacemaker	☐	☐
Angina (Chest Pain)	☐	☐
Myocardial Infarction (Heart Attack)	☐	☐
Blood Clot/DVT	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Congestive Heart Failure	☐	☐
History of Smoking	☐	☐
Anemia	☐	☐

Pulmonary System:

	Yes	No
Asthma	☐	☐
Difficulty Breathing	☐	☐
Emphysema	☐	☐
Prolonged Cough	☐	☐
COPD	☐	☐

Other:

	Yes	No
Diabetes	☐	☐
Cancer	☐	☐
Kidney Disease	☐	☐
Thyroid	☐	☐
Fatigue	☐	☐
Weakness	☐	☐

Surgical History:
Please list type of surgery and approximate dates:

Your Goals:
Please list 3 goals you would like to achieve for your physical therapy:

1.

2.

3.

IN CASE OF EMERGENCY, PLEASE CONTACT

Name: Relationship:

Home Phone:

Cell Phone: