MARSHALL

Rehabilitation Services Intake Form

Name: ______________________________ Date: ____________

Date of injury or onset for your symptoms/problems: ______________________________

What are your symptoms/problems? ______________________________

____

What are your functional limitations? (What is it keeping you from being able to do?)

____

____

How did it happen? ______________________________

____

____

Is your condition improving, getting worse, or remaining the same? ______________________________

List any diagnostic studies you have had for this problem: ______________________________

____

List any previous surgeries or medical conditions that may affect your performance in therapy:

____

Have you ever had treatment for this condition? ☐ Yes ☐ No

Did it help? ☐ Yes ☐ No

Are you taking any medication for this condition? ☐ Yes ☐ No

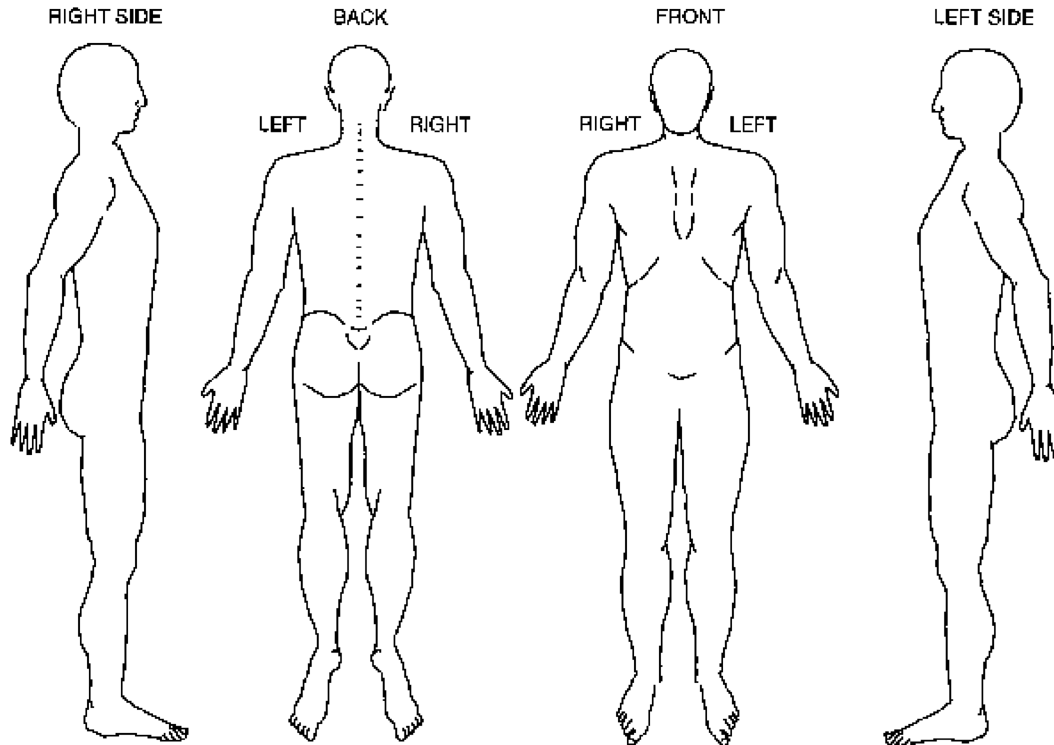
What results are you hoping to get from therapy? ______________________________

____

(continued on next page)

Rehabilitation Services Intake Form

Color the body part where you have pain or circle the part of the body that you are having difficulties with.



MARSHALL

Rehabilitation Services Intake Form

Let's work together

Marshall Medical Center's Rehabilitation Services strives to provide you the best personalized care available. Your successful rehabilitation depends not only on the skill of your Physical Therapist, but on your commitment, attendance and follow through. To make this possible, we ask that you make every effort to comply with our guidelines below.

Please read and initial all boxes below and sign at the bottom, indicating you have read and understood the information.

_____ **24 - Hour Advance Notice** – If you wish to change or cancel an appointment we request the courtesy of a 24-hour notice. The therapist's time is set aside exclusively for you. Advance notice allows someone else who may be waiting the time to reserve the appointment in your place.

_____ **No Show** – Attendance at therapy is critical to a successful outcome. If you fail to show up for two appointments without notice, all future scheduled appointments will be cancelled and you will need to call to reschedule. On the 3rd no show, your chart will be discharged and a note sent to your physician.

_____ **Late Policy** – If you are going to be late, we ask that you notify our office. Your therapist may have to shorten your treatment time or reschedule the appointment if you are more than 10 minutes late.

_____ **Copays are due upon arrival** – Please come prepared to pay your copay at the time of service. Marshall offers a discount on the full bill for those who consistently make their co-payment at the time of service.

_____ **Financial Hardship** – If you are experiencing financial difficulties and are unable to afford the cost of services, Marshall has financial assistance programs that may help. Please ask the front desk for assistance.

_____ **Cell phones must be OFF or silent** – We realize emergencies may arise and so be courteous and set to silent or vibration mode during your therapy session.

Thank you for taking the time to read and understand our policy. If you have any questions, please do not hesitate to discuss them with your therapist.

We look forward to partnering with you for a successful outcome!

Patient Signature: ______________________ Date: __________ Time: __________