



FUNCTION FIRST PHYSICAL THERAPY, LLC

PATIENT INFORMATION, ADMINISTRATIVE INFORMATION & CONSENTS

Patient Information

Name: _____	DOB: _____
Sex at Birth: _____	Cell Phone: _____
Address: _____	City/State/Zip: _____
E-mail: _____	Primary Care Physician: _____
Preferred Appointment Reminders: ☐ Text ☐ Call ☐ E-mail ☐ None	Who Referred You? _____

Insurance / Responsible Party

Insurance: _____	Guarantor / Responsible Party (if different): _____
Guarantor DOB: _____	Relationship to Patient: _____

Emergency Contact

Name: _____	Relationship: _____
Phone: _____	Alternate Phone: _____

Consent to Physical Therapy Evaluation and Treatment

I consent to the evaluation and treatment of my condition by a licensed therapist employed by Function First Physical Therapy, LLC. My therapist will explain the nature and purpose of the evaluation and proposed treatment, including expected benefits, material risks or discomforts, and reasonable alternatives when applicable. I understand that I may ask questions at any time and may refuse or discontinue any treatment.

Assignment of Benefits & Insurance

I authorize payment of applicable medical benefits to Function First Physical Therapy, LLC for services rendered. I understand that verification of benefits or acceptance of assignment is not a guarantee of payment and does not relieve me of responsibility for amounts determined to be my responsibility under my coverage.

Cancellation / No-Show Policy

Appointments must be cancelled or rescheduled by 5:00 PM on the preceding business day. Same-day cancellations and missed appointments are subject to a \$25 fee, which must be paid before the next visit. If my insurance plan prohibits Function First Physical Therapy from charging a cancellation or no-show fee, the fee will not be charged. Instead, three (3) same-day cancellations and/or missed appointments may result in discharge from therapy and cancellation of remaining scheduled appointments.

Privacy / HIPAA Acknowledgment

I acknowledge receipt or availability of Function First Physical Therapy, LLC's Notice of Privacy Practices. I understand that my protected health information may be used and disclosed as permitted by law for treatment, payment, and healthcare operations. I understand that I may request restrictions or exercise other privacy rights as described in the Notice of Privacy Practices.

Recording, Dictation, Transcription & AI-Assisted Documentation

Function First Physical Therapy may use secure dictation, transcription, audio-recording, and artificial intelligence (AI)-assisted tools to help clinicians prepare medical documentation. These tools may process information discussed during my visit, including protected health information. They assist with documentation and do not replace the treating clinician's professional judgment. I understand that I may decline audio recording or AI-assisted transcription of my visit without affecting my right to receive treatment.

Audio recording / AI-assisted transcription: ☐ I CONSENT ☐ I DO NOT CONSENT

Patient/Authorized Representative Signature: _____	Date: _____
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PATIENT INTAKE - MEDICAL HISTORY

Current Medical Conditions & Services

Receiving other therapy and/or Home Health, including nursing? ☐ No ☐ Yes	If Home Health, last service date: _____
Open liability or workers' compensation claim? ☐ No ☐ Yes	Medical/physical activity restrictions? ☐ No ☐ Yes
Pacemaker or other implanted device? ☐ No ☐ Yes	If yes, specify: _____
Current tobacco use? ☐ No ☐ Yes	Pregnant? ☐ No ☐ Yes Months: _____
Allergies? ☐ No ☐ Yes	If yes, specify: _____
Past injuries/surgeries: _____	

Medical Conditions - Check All That Apply

☐ No past/current conditions	☐ Depression	☐ Immunosuppression
☐ Alzheimer's disease	☐ Diabetes Type I	☐ Lupus
☐ Anxiety	☐ Diabetes Type II	☐ Muscular dystrophy
☐ Cardiovascular disease	☐ Fibromyalgia	☐ Obesity
☐ Cauda equina syndrome	☐ High cholesterol	☐ Osteoarthritis
☐ Cerebrovascular accident / stroke	☐ High or low blood pressure	☐ Parkinson's disease
☐ Current infection	☐ History of cancer	☐ Rheumatoid arthritis
☐ Current fracture	☐ Huntington's disease	☐ Traumatic brain injury
☐ HIV	☐ Osteoporosis	☐ Urinary incontinence
☐ Seizure disorder	☐ Blood clot / DVT / PE	☐ Kidney disease
☐ Lung / respiratory disease	☐ Dizziness / fainting	☐ Joint replacement / metal implant
Other: _____		

Advance Care Information - If Applicable

☐ Out-of-hospital DNR ☐ Healthcare Power of Attorney ☐ Other directive: _____	
Preferred Hospital: _____	Additional information: _____

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CURRENT MEDICATIONS

Please list current medications below. You may attach or provide a separate medication list instead.

Medication	Dose	How Often

☐ No current medications ☐ Medication list provided separately ☐ Taking blood thinner/anticoagulant

Please inform Function First Physical Therapy of significant medication changes during your course of care.

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CURRENT COMPLAINT, PAIN & FALL SCREEN

Major Complaint

What is your major complaint? _____

Onset Date: _____

Specific injury? ☐ No ☐ Yes

Surgery performed? ☐ No ☐ Yes

Surgery Date: _____

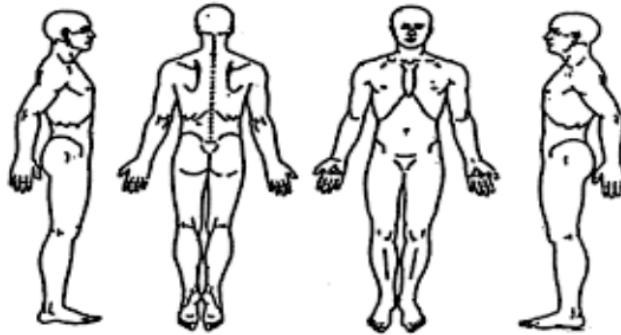
Pain

Pain? ☐ Yes ☐ N/A If applicable, circle one number for each:

Worst Pain	0 1 2 3 4 5 6 7 8 9 10
Current Pain	0 1 2 3 4 5 6 7 8 9 10
Best Pain	0 1 2 3 4 5 6 7 8 9 10

Pain / Discomfort Location

Please mark location(s) of pain on the body views below.



Are you experiencing pain/discomfort in any of the following areas? (MIPS/outcome measure)

☐ Shoulder ☐ Elbow/Wrist/Hand ☐ Lumbar/Thoracic Spine ☐ Hip ☐ Knee ☐ Foot/Ankle

Fall Screening

Are you over age 65? ☐ No ☐ Yes

Have you had 2 or more falls? ☐ No ☐ Yes

Have you had a fall resulting in injury? ☐ No ☐ Yes

If yes, specify: _____

Patient Attestation

I certify that the information I have provided is accurate and complete to the best of my knowledge. I understand that this information is used to assist in my evaluation and treatment, and I agree to inform Function First Physical Therapy of any significant changes in my health, medications, or medical condition during my course of care.

Patient/Authorized Representative Signature: _____

Date: _____