611 E Star Court, Suite B
Montrose, CO 81401
inmotiontherapymontrose.com

P 970-249-1646
F 970-249-8899

Patient Information

Date ______________________________

Patient name First _________________________________ Middle Initial __________ Last ______________________________

Address _________________________________ City _______________________ State _________ Zip ________

Date of birth ________________________ Age _________ Sex __________ Marital status ______________________________

Social Security # ____________________________ Height ______________ Weight _____________

Best Phone # ________________________ **Text Reminder?** ☐ **OR Call Reminder?** ☐ **Ok to leave message?** ☐

Secondary Phone # __________________________ Email address ____

Employer _________________________________ Work # ____

Emergency Contact _______________________________________ Relationship to Patient ______________________________

Phone # ____________________________ Cell # _____________________________ Work # ____________________________

Who may we speak with regarding your care?

Name _______________________ Phone _____________________________ Relationship _____________________________

Referring provider's name ____ Phone # __________________________________

Primary Care Physician name _______________________________________ Phone # __________________________________

How did you hear about us? ____

Responsible Party Information (under 18 years of age)

Name First _______________________________________ Middle Initial ____ Last ____________________________________

Date of birth ________________________________ Relationship to patient ____

Insurance Information

Are you covered by Colorado Medicaid? _______________ **Are you applying for Colorado Medicaid**? ______________

Primary Insurance ________________________________ Policy # _______________________ Group # __________________

Policy Holder Name ______________________________________ Policy Holder Date of Birth ____________________________

Secondary Insurance ______________________________ Policy # _______________________ Group # __________________

Policy Holder Name ______________________________________ Policy Holder Date of Birth ____________________________

Is this an Auto accident? _________ **Is this Workers Compensation?** _______ Claim # ____________________________________

Date of Injury __________________ Adjuster First and Last Name ____________________ Adjuster Phone ____________________

Patient Consent

- I have received, understand, and agree to all information included and described in the In Motion Therapy Notice of Privacy Practices.

- I hereby authorize payment of medical benefits billed to my insurance by In Motion Therapy. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I understand that any unpaid balances will be my responsibility and I may be charged interest of 1.5% per month for unpaid amounts 90 days past due.

- **We require a 24 hour notice for cancellations.** If you do not call to cancel or fail to show for an appointment you may be charged a rescheduling fee. If you miss 3 consecutive appointments we will notify your physician and will require you to obtain a new referral in order to continue your treatment.

Signature of Patient or Patient's Representative ____ Date ___________________

Printed Name of Representative _____________________________ Relationship of Representative to Patient ___________________

611 E Star Court, Suite B
Montrose, CO 81401
inmotiontherapymontrose.com

P 970-249-1646
F 970-249-8899

Name: ____ **Date:**__________

What body part are you being seen for today?________________________ Circle one: Right Left Both

When and ***how*** did your problem start? (If specific date is unknown, please estimate time of year)

____

Did you have surgery for this problem? __________________________ Date of Surgery: ___________________

Pertaining to this problem you are being seen for today, have you had any:

X-Ray Date:_______ Location:________________ **MRI** Date:________ Location:__________________

CT Date:_______ Location:________________ **EMG** Date:________ Location:__________________

Other:____

Please rate your pain on a scale of **0** (no pain) to **10** (unbearable):

At Worst_______/10 Current_______/10 At Best _______/10

Describe your pain (please circle ***one*** that most applies):

burning sharp dull/ achy throbbing shooting numbness/tingling

constant intermittent worse in morning worse in evening

What makes your pain worse? ____

What makes your pain better? ____

Are any of your daily activities affected? If so, how? ______________________________________

What are your **goals** for therapy? ____

MEDICAL HISTORY Please circle all that applies to you:

Alzheimer's	Cancer Type: Year:	Traumatic brain injury Type: Year:	Fracture/Expected Fracture
Cardiovascular Disease Type: Year:	Huntington's Disease	Immunosuppression	Unexplained Weight Loss
Stroke/TIA Type: Year:	Lupus	Blood Clots	Parkinson's Disease
Current Infection Type:	Multiple Sclerosis	Dizziness	Obesity
Diabetes Type:	Muscular Dystrophy	Falls	Pacemaker
Fibromyalgia	Rheumatoid Arthritis	Headaches	Osteoporosis
High Blood Pressure	Osteoarthritis	Mental Health Illness Type:	Do You Smoke:

Please list or attach current medications and/or supplements: ______________________________

____

Do you have any allergies? ____

Have you had any physical or occupational therapy this year? __________________________

Are you receiving or have you received home health care of any kind this year? _______________

DO YOU HAVE A PACEMAKER? __________

I hereby consent to the evaluation and treatment of my condition by a licensed therapy provider employed by In Motion Therapy.

Patient Signature: ____ Date: ____________