14 Vittum Rd, Bldg 1
Ellsworth, ME 04605
T: 207-992-4000
F: 207-558-3285
admin@ube-more.com

130 Perry Rd
Bangor, ME 04401
T: 207-992-4000
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Patient Intake and Demographic Sheet

PATIENT DEMOGRAPHICS:

Patient Name: _____ Mobile/Home Phone: _____

Address: _____ DOB: _____

City:_____ State: _____ Zip:_____ Age:____ Sex: __ Marital Status: _____

Family member holding the policy: _____ Their DOB: _____

Email Address: _____Work phone: _____

*How did you hear about our facility?_____

How would you prefer to receive invoices for your account balance? Email ☐ Mail ☐

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for UBE Physical Therapy. I recognize that I must give my written authorization to UBE to release any of my protected healthcare information in instances beyond purposes for treatment, payment, certain healthcare operations, or in instances required or permitted by law.

Patient Name: _____
(Please Print)

Patient or Authorized Representative: _____ Date: _____
(Signature)

By signing your name electronically, you are agreeing that your electronic signature is equivalent to your manual signature.

INFORMED CONSENT FOR CARE AND TREATMENT

UBE Physical Therapy and its employees, volunteers, and students use a variety of procedures and modalities to help improve an individual's function. As with all forms of medical treatment, there are benefits and risks involved with PT and can vary widely from person to person.

You have the right to ask your PT what type of treatment is planned for you. You may discuss the potential risks and benefits of treatment and the outcomes of choosing not to receive treatment. You have the right to stop treatment at any time.

I acknowledge that my treatment program has been explained and all of my questions have been answered to my satisfaction. I understand the risks associated with treatment, and I wish to proceed.

I, the undersigned, do hereby agree and give my consent for UBE Physical Therapy to furnish medical treatment to (please PRINT name).

_____

Patient/guardian signature:_____ Date:_____

By signing your name electronically, you are agreeing that your electronic signature is equivalent to your manual signature.

UBE PHYSICAL THERAPY AND PERFORMANCE

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PAST MEDICAL HISTORY

Name:_____ Birth Date:_____

What are we seeing you for?_____

Accident/injury date:_____ Have you had surgery for this injury? ☐ YES ☐ NO

Type of Surgery: _____ Surgeon:_____ Restrictions? ☐ YES ☐ NO

Current level of pain between 0-10 (0 being no pain, 10 being pain for ER care)_____

Are you currently taking any prescription or non-prescription medications? ☐ YES ☐ NO

List Medications:_____

_____

Have you had any of the following medical and rehabilitative services for this injury or episode?

	YES	NO		YES	NO
Physical Therapy	☐	☐	Chiropractor	☐	☐
Massage Therapy	☐	☐	Occupational Therapy	☐	☐
Neurologist	☐	☐	Orthopedist	☐	☐
X-rays	☐	☐	MRI	☐	☐
EMG/NVC	☐	☐	CT Scan	☐	☐

Other:_____

Do you now have or have you EVER had any of the following:

	YES	NO		YES	NO
Asthma, bronchitis	☐	☐	Headaches/migraines	☐	☐
Shortness of breath/chest pain	☐	☐	Vision/hearing difficulties	☐	☐
Do you have a pacemaker?	☐	☐	Numbness/tingling	☐	☐
High blood pressure	☐	☐	Weakness	☐	☐
Heart attack	☐	☐	Dizziness/fainting	☐	☐
Stroke/TIA	☐	☐	Blood clot/emboli	☐	☐
Epilepsy/seizures	☐	☐	Allergies	☐	☐
Anemia/bleeding disorder	☐	☐	Any pins/metal implants	☐	☐
Infectious disease	☐	☐	Joint replacement	☐	☐
Emotional/psychological problems	☐	☐	Diabetes	☐	☐
Arthritis	☐	☐	Cancer or chemotherapy/radiation	☐	☐
Sleeping problems	☐	☐	Osteoporosis	☐	☐
Are you pregnant?	☐	☐	Bowel/bladder dysfunction	☐	☐

Are you aware of what your diagnosis is? ☐ YES ☐ NO

Based upon your awareness, what are your expectations/goals while in this program?

_____

How many times have you fallen in the last 12 months?_____ Did you injury yourself with the falls? ☐ YES ☐ NO. How did you fall?_____

Do you feel as though your weight is a problem? ☐ YES ☐ NO. If yes, have you talked with your PCP regarding this concern?_____