Global Rehabilitation & Sports Medicine LLC

Initial Intake Form

Name:_____ Date of Birth:_____

Address:_____ Zip Code:_____

Phone Number:_____ Email:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

How did you hear about us?:_____

Primary Complaint(What is bring you in today?):_____

When did it begin?: _____

Current Pain (1-10):____ Best:____ Worst:____

Please check YES if you currently have, or have recently experienced, any of the following:
☐ Yes ☐ No — Unexplained fever, chills, night sweats, or feeling unusually ill
☐ Yes ☐ No — Unexplained weight loss, loss of appetite, or unusual persistent fatigue
☐ Yes ☐ No — A personal history of cancer or a new/unexplained lump or mass
☐ Yes ☐ No — History of osteoporosis, prolonged steroid use, or frequent/unexplained fractures
☐ Yes ☐ No — Pain that is severe, rapidly worsening, constant, or not affected by movement or position
☐ Yes ☐ No — New or rapidly worsening weakness, numbness, tingling, difficulty walking, loss of balance, or coordination problems
☐ Yes ☐ No — New difficulty controlling your bladder or bowels, difficulty starting urination, or numbness around the groin/genital/inner-thigh area
☐ Yes ☐ No — New or unusual severe headache or neck pain accompanied by dizziness, double vision, difficulty speaking/swallowing, fainting, facial symptoms, or difficulty walking
☐ Yes ☐ No — New or unexplained chest pain/pressure, shortness of breath, fainting, racing/irregular heartbeat, or unusual sweating
☐ Yes ☐ No — New unexplained swelling, warmth, redness, discoloration, or significant pain in one arm or leg
☐ Yes ☐ No — A recent surgery, hospitalization, prolonged period of immobility, or previous blood clot
☐ Yes ☐ No — Unexplained abdominal, pelvic, flank, or back pain that does not seem related to movement
☐ Yes ☐ No — Blood in your urine or stool, black/tarry stool, persistent vomiting, or unexplained changes in bowel or bladder function

If YES to any question above, please explain:

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Are you currently taking any of the following?

☐ Blood thinner/anticoagulant
☐ Long-term corticosteroid
☐ Immunosuppressive medication
☐ Cancer treatment
☐ Hormone therapy
☐ None of the above

Current Care
Are you currently seeing anyone else for this condition? ☐ Yes ☐ No

If yes, who? _____

Have you received imaging for this condition? (x-ray, MRI, CT scan, Ultrasound,etc.)
_____ If so, when? _____

What are your goals for therapy?

_____

PURPOSE AND NATURE OF SERVICES

I, the undersigned patient, hereby consent to receive **physical therapy evaluation and treatment** from Global Rehabilitation and Sports Medicine, LLC (“the Practice”), including but not limited to:

- Physical therapy examination and functional assessment
- Development and implementation of a treatment plan
- Therapeutic exercise, activity, and neuromuscular re-education
- Manual therapy, joint mobilization, and soft tissue techniques
- Myofascial release, cupping, dry needling, or instrument-assisted soft tissue mobilization (as appropriate)
- Pelvic health evaluation and treatment, which may include internal and/or external assessment

- Education regarding movement, posture, exercise, bladder and bowel function, and self-management strategies

I understand that physical therapy is a collaborative process that involves my participation and feedback to ensure safety and effectiveness.

Initial _____

CASH-BASED PRACTICE ACKNOWLEDGMENT

I acknowledge that Global Rehabilitation and Sports Medicine, LLC is a **cash-based physical therapy practice**, and:

- Payment is due in full at the time of service.
- The Practice does **not** bill or communicate directly with insurance companies.
- I am responsible for any insurance claim submissions for possible reimbursement.
- All fees, payment methods, and cancellation policies have been explained to me in advance.

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LIMITATION OF GUARANTEES

I understand that physical therapy outcomes vary among individuals. No guarantees have been made regarding specific results or timelines. My therapist will provide evidence-based care and professional judgment but cannot promise complete resolution of symptoms.

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PATIENT RESPONSIBILITIES

I understand that my active participation—including performing home exercises, attending sessions, and communicating changes in my condition—is essential for achieving desired outcomes.

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MEDICAL HISTORY DISCLOSURE

I have accurately disclosed all relevant medical history, medications, allergies, and surgeries. I agree to inform my therapist of any changes to my health status that may affect care or safety.

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PRIVACY AND CONFIDENTIALITY

I understand that all personal and medical information is confidential and protected under the **Health Insurance Portability and Accountability Act (HIPAA)**. Information will not be released without my written authorization, except as required by law.

Initial _____

RELEASE OF LIABILITY

In consideration for receiving services from Global Rehabilitation and Sports Medicine, LLC, I hereby release, discharge, and hold harmless the Practice, its owner, employees, and contractors from any and all liability, claims, or demands arising from participation in physical therapy, including but not limited to:

- Temporary discomfort, soreness, or symptom aggravation
- Misapplication of home exercise or educational material
- Incidental or consequential injury related to participation in therapy

This release applies to all services rendered now or in the future, unless revoked in writing.

Initial _____

PATIENT RIGHTS

I understand that I have the right to:

- Receive information about proposed treatments and alternatives,
- Refuse or withdraw consent for any portion of care,

- Ask questions and receive clear explanations,
- Request referral to another healthcare provider.

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ACKNOWLEDGMENT AND SIGNATURE

By signing below, I acknowledge that:

- I have read and fully understand this Consent to Treat and Liability Release Agreement.
- All questions have been answered to my satisfaction.
- I consent voluntarily to receive evaluation and treatment.
- I release Global Rehabilitation and Sports Medicine, LLC and its representatives from liability related to my participation in care, to the fullest extent permitted by Florida law.

Initial _____

Patient Name: _____

Patient Signature: _____
Date: _____

Therapist Name: _____
Therapist Signature: _____
Date: _____