Gaithersburg Regenerative Medicine and Laser Center
60 Market Street, Suite 202 • Gaithersburg, MD 20878 • 301-330-5666

Patient Intake Form

Please take a few minutes to answer the following questions about your health and lifestyle to assist us in expediting your evaluation:

Date: _____ Patient's Name: _____

Age: _____ Height: _____ Weight: _____ Primary Care Physician: _____

Last appointment with Physician: ____within 6 months ____within past year ____more than 1 year ago

How do you learn best? ____verbally ____written ____visually ____demonstration and practice

What is the reason you are coming to Physical Therapy? _____

_____

_____

_____

_____

When did your symptoms begin? _____

Are your symptoms the result of: ____accident ____injury ____recent surgery ____slow onset

Diagnostic Tests: ____X-ray ____MRI ____CT-scan ____other: _____

Have you seen a medical doctor about your concerns, and, if so, what are your understandings about the diagnosis? Yes / No. _____

_____

What treatments have you already tried for your current issue? ____ice ____heat ____rest

____ other: _____

Living conditions: ____apartment ____house ____multiple family dwelling

____flights of stairs: #_____ ____railing on stairs: ____right side ____left side ____both

____elevator ____live alone ____live with family ____live with others

What is your occupation? _____

If you currently take any medication or supplements on a regular basis, please list medication and reason for medication:

_____

_____

_____

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Do you have any of the following?

____AIDS/HIV	____Circulatory Problems	____Epilepsy
____Diabetes	____High Blood Pressure	____Low Blood Pressure
____Heart Problems	____Heart Attack	____Lung/Respiratory Problems
____Chest Pain	____Asthma	____Bladder or Kidney Dysfunction
____Cancer	____Bleeding Disorders	____Rheumatoid Arthritis
____Ear Problems	____Chemical Dependency	____Blood Disorder (_____)

____Osteoarthritis (if yes, where: _____)

____Surgery (if yes, please list: _____)

____Allergies (if yes, please list: _____)

____Other: _____

Please describe your pain by answering the following prompts:

Location: _____

What makes your pain worse? _____

What makes your pain better? _____

What time of day is you pain the worst? _____

Describe your pain: ____sharp ____dull ____achy ____tingling ____numb ____radiating

____other (please describe: _____)

Rate your pain on a scale of 0-10 where 0 is no pain and 10 pain would require a trip to the emergency room. On this scale what level is your pain at best? _____ at worst? _____

Is your pain ____constant or ____intermittent?

Does the pain prevent you from sleeping or wake you in the middle of the night? ____yes ____no

What activities do you feel that you cannot fully participate in because of this pain or condition? _____

_____

Are you currently, or have you been within the past year, under the care of any other medical professional?

_____

_____

Consent

I certify that the above information is true and correct to the best of my knowledge. I have been allowed my free choice in the selection of a rehab/ wellness provider and have been allowed to exercise that free choice. I voluntarily consent to receive rehab/ wellness services.

Patient Signature: _____ Date: _____

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Patient Financial Agreement

Welcome to Gaithersburg Regenerative Medicine and Laser Center. We provide physical therapy and wellness services for a variety of medical problems. Some insurance companies may require a script from your physician, dentist, or podiatrist in order to cover your PT services. These scripts are generally valid for 1 month and should be provided to us on your first visit, if needed. If you are planning to submit to your insurance company for reimbursement, please contact them and ask for your out-of-network benefits and whether a script is necessary. You can use your flex spending/ HSA to pay for your services. Patients who have Medicare as part of their insurance plan cannot submit for reimbursement. Fitness and wellness services are provided for Medicare patients, and if the need for skilled PT intervention arises, a referral to a Medicare-contracted provider will be offered.

- Appointments will usually last 25-30 minutes ($90) or 50-60 minutes ($180).
- Shockwave therapy is an additional service that has an added cost. Each shockwave session is an additional $60 charge. A 25-30 minute PT session with shockwave is $150 and a 50-60 minute PT session with shockwave is $240
- Please arrive 15 minutes early for your first appointment to complete intake paperwork.
- Please arrive promptly for each scheduled follow up appointment. If you are more than 10 minutes late, your therapist's schedule may prevent you from being seen or your treatment time will be limited.
- Gaithersburg Regenerative Medicine and Laser Center requires 24 hour notice of cancellation of a scheduled appointment. You may be financially responsible for later cancellations and missed appointments (no-shows). We reserve the right to charge for time reserved without proper cancellation. The cancellation fee is $50.

I understand and agree that I am financially responsible for full payment of my bill. _____(Initial)

I understand that the cost of therapy is dependent on the duration of the appointment and additional services that I may agree to have as part of my treatments. _____(Initial)

I consent to this agreement as of the _____ day of _____, 2022 .

_____ (Patient's Name, Printed)

_____ (Patient's Signature)

_____ (Witness's Name, Printed)

_____ (Witness's Signature)