6520 3rd Street Rockledge, FL 32955 P (321) 622-8792 F (321) 622-8793

Adult Intake Form

Name ______________________________________ Birth date _______________ Age _____ Gender M F

Home Phone ___________________ Cell Phone ___________________

Address____

City _______________________________ State ____________________ Zip ________________

Email Address ____

I consent to receiving email communication Yes No

Reason for referral ____

Insurance Information

Insured's Name (if different from patient)____

Relationship to patient ____ Insured's DOB ____________________________

Insurance____

Group #____________________________________ ID# or SS# ____

Insurance phone# ____

Referred by____

Doctor's Name ____

Doctor's Address ____ Doctor's Phone ______________________

Last doctor visit _____________________________

Health History

Have you received any physical therapy this year? Yes No

If yes, please explain ____

Please mark if you have any of the following:

atrial fibrillation seizures chronic colds pacemaker pneumonia

diabetes heart attack asthma COPD

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Any other serious or recurrent illnesses? ____

Current general health ____

Current medications:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Hearing difficulties ______________________ hearing aids ______________________

Vision difficulties ______________________ glasses/contacts ______________________

Dental problems ______________________ treatment ______________________

Other ____

Ongoing medical care ____

Chronic health problems ____

Any speech or hearing problems in family? ____

Other languages spoken in home? ____

What are your communication needs in social settings? ____

____

What are your communication needs in work setting? ____

____

What difficulties do you have meeting your communication needs? ____

____

Educational History

Highest education level (Select one): High School Some College Bachelors Masters

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Does communication affect your performance in school? ____

On the job? ____________________________ plans for the future? ___________________________________

Hobbies ____

Social groups to which you belong ____

Other info you would like us to know ____

____

____

PLEASE READ AND SIGN THE FOLLOWING

I give permission for Taylor Made Therapies, LLC and contracted therapists to evaluate and treat me.

Signature ____ Date _______________________

I have reviewed and received Taylor Made Therapies LLC's HIPAA Policy Statement.

Signature ____ Date _______________________

I authorize release of any medical or other information necessary to process this claim, including release of information to my Primary Care Physician as designated above and directly to the insurance company. I authorize payment of medical benefits to Taylor Made Therapies, LLC for services provided. I request and assign benefits to Taylor Made Therapies, LLC for all insurance benefits otherwise payable to me for services rendered.

Signature ____ Date _______________________

I authorize discussion of my case with the following specific individuals

____

____

Signature____ Date _______________________