

Name: _____
(First) (Middle) (Last)

Local Address: _____
(Street) (Apt, Ste, Unit) (City) (State) (Zip)

Northern Address: _____
(Street) (Apt, Ste, Unit) (City) (State) (Zip)

Phone: _____
(Home) (Work or Northern Phone) (Cell Phone)

Email Address: _____

Soc. Sec #: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** M F
Month/Day/Year Circle One

Marital Status (circle): Single Married Divorced Widow

Employment Status (circle): Full Time Part Time Not Employed Retired

Employer: _____
(Name) (Address)

In case of an emergency, Notify: _____
(Name) (Phone #) (Relation)

Is the illness/injury for which you are being seen the result of any of the following? Circle One:

Auto Accident Work Injury Other Litigation None of these

Is there an attorney involved in relation to your injury/illness? Circle One: YES NO

If yes: _____
(Name of Attorney) (Address) (Phone)

Please provide us with your insurance information. You will need to supply our office with a copy of each of your insurance cards as well as a copy of your driver's license. If you are unable to supply us with a copy of ALL of your insurance cards and we are unable to verify that your insurance is current you must pay for your visit by cash. We accept checks, cash, Visa, or Mastercard.

If you are not the insured person under your insurance policy please provide the INSURED's information.

Insured's Name: _____

Insured's Date of Birth: _____

Consent To Treat & Authorization To Release Information

Please read and initial the following:

_____ I consent to *evaluation & treatment* by Medical & Sports Rehabilitation Center, Inc and realize I have the right to refuse any procedure after having the risks & benefits explained to me.

_____ I authorize the **release of information** acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or third party payer.

_____ I authorize *phone messages* regarding my treatment & appointments to be left with persons or machines at the phone numbers I have provided.

_____ A copy of this facility's *Statement of Privacy Notice* has been provided to me.

FOR MEDICARE PATIENTS ONLY: Please answer the following 5 questions YES or NO

1. Do you or your spouse work full or part-time? _____
2. Do you or your spouse still have Primary Health Insurance coverage through an employer? _____
3. Was your injury/condition caused by an automobile, work, service-related, or any other accident for which someone else will be responsible for your medical expenses? _____
4. Do you receive MEDICARE due to kidney disease? _____
5. Have you received any form of therapy (physical, occupational, or speech) prior to attending therapy at our facility? _____

If you answered YES to any of the above questions please advise the front office. It may be possible that Medicare is not your primary insurance.

Please Sign Below

Patient's Signature: _____

Date: _____

Signature of Responsible Party: _____

Date: _____

(If different from patient)

Relation To Patient: _____

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION

Interests/hobbies/exercise: _____

Is there anyone who can assist you with doing home exercises or activities if needed? Yes No

Will you have any problems attending therapy sessions? No Yes If yes, please describe:

Next scheduled Dr Appointment: Date _____ Physician _____

KEY QUESTIONS ABOUT YOUR CONDITION

What is your **MAIN** complaint?

Darken the areas on the body where you are having problems

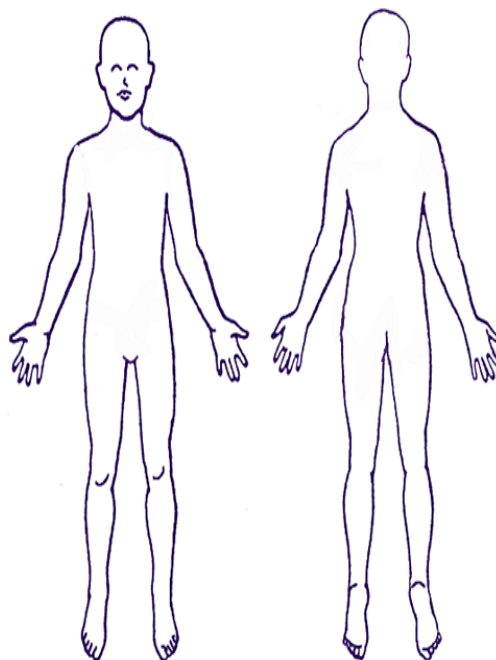
Please mark your level of pain with a **X** along the following lines:

What is your pain at rest?

No Pain Worst Pain
Imaginable

What is your pain with activity?

No Pain Worst Pain
Imaginable



GENERAL HEALTH

Are you having trouble sleeping? _____YES _____NO

Normal hours of sleep _____ hours Current hours of sleep _____ hours

Medical conditions you have or have had. Check all that apply.

- Fever, Chills, or Sweats Arthritis Stroke Visual Problems
- Bowel Dysfunction Cancer Stomach Disorders Hearing Problems
- Numbness Diabetes Anxiety Neurological Disorders
- Weakness Heart Disease Depression Osteoporosis
- Night Pain High Blood Pressure Panic Attacks Fibromyalgia
- Weight Change Lung Disease Pacemaker Epilepsy
- Fatigue Nausea/Vomiting Shortness of Breath Parkinson's Disease
- HIV Positive AIDS Vascular Disorder Hemophilia
- Other: _____

Are you taking any medications (prescription, over the counter, herbal preparations)? YES NO

If yes, please list or provide us with a list. _____

Do you have any allergies (adhesives, latex, cortisone, medications)? YES NO

If yes, please list with any reaction/treatments:

	Reaction/Treat _____
	Reaction/Treat _____
	Reaction/Treat _____

PERSONAL GOALS FOR THERAPY

What do **YOU** want to achieve from having therapy? Check all that apply.

- Improve home activities Improve mobility Improve range of motion
- Improve leisure/sports activities Decrease pain/discomfort Improve endurance
- Improve self care activities Return to work Improve balance/walking

Please include any additional information you feel would help us to provide your care. (What you think would help any apprehensions about treatment, special communication, language, spiritual or cultural needs). _____

To the best of my knowledge the above information is complete and factual.

Patient Signature

Date