

**MEDICAL & SPORTS
REHABILITATION CENTER, INC.**

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

Local Address: _____
(Street) (Apt, Ste, Unit)

(City) (State) (Zip Code)

Northern Address: _____
(Street) (Apt, Ste, Unit)

(City) (State) (Zip Code)

Nickname: _____ **Referring Physician:** _____

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

Email Address: _____

Soc. Sec #: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** ___M ___F
Month/Day/Year

Marital Status: _____ Single _____ Married _____ Divorced _____ Widow

Employment Status: _____ FT _____ PT _____ Not Employed _____ Retired _____ Student

Employer: _____ **Work Phone #:** _____

Emergency Contact: _____
(Name) (Phone #)

Emergency Contact Relation (spouse, friend, parent, etc): _____

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

_____ Auto Accident _____ Work Injury _____ Other Litigation _____ None of these

Is there an attorney involved in relation to your injury/illness? _____ YES _____ NO

If yes: _____
(Name of Attorney) (Attorney's Phone #)

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

Please indicate your present level of activity for each area listed below and mark the option that best describes each ability.

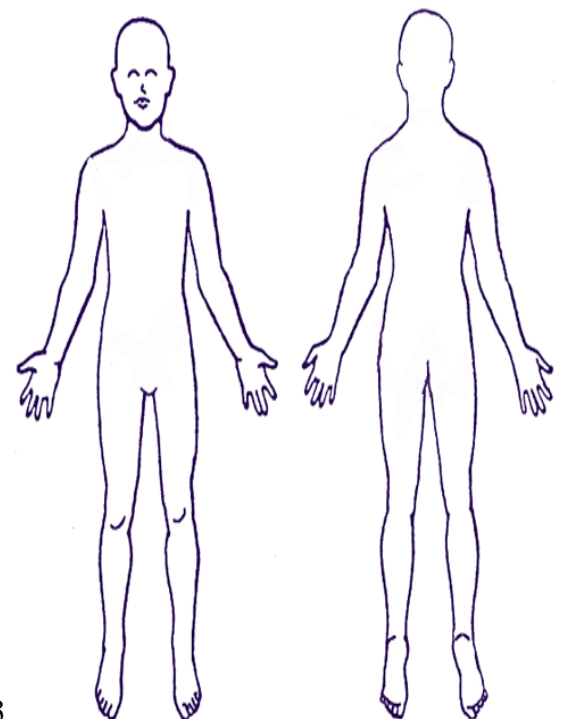
	No Problems	Mild Difficulties	Moderate Difficulties	Severe Difficulties	Unable To Perform
Sleeping					
Getting Up From Sitting					
Dressing & Bathing					
Walking					
Climbing Steps					
Lifting & Carrying					
Kneeling/Squatting					
Traveling					
Recreational & Social Activities					
Working					

Check the box that describes your pain level at rest
(Zero = no pain & 10 = severe pain)

0	1	2	3	4	5	6	7	8	9	10

Check the box that describes your pain level at with activity
(Zero = no pain & 10 = severe pain)

0	1	2	3	4	5	6	7	8	9	10



Place an "X" the areas on the body where you have pain or numbness.

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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.

_____ To the best of my knowledge the information I provided on the "History Questionnaire" is complete and factual.

_____ 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.

_____ I authorize **email messages** regarding my treatment & appointments to be sent to the email address I have provided.

_____ I authorize Medical & Sports Rehabilitation Center, Inc to discuss my account with the following person/s (for example: husband, personal assistant, etc). I understand that if I do not list anyone then my account may only be discussed with me.

_____ (Authorized Person)

_____ (Relation)

_____ (Authorized Person)

_____ (Relation)

_____ A copy of this facility's **Statement of Privacy Notice** has been provided to me. You may find this brochure in our waiting area.

Patient's Signature: X _____

Date: _____

Signature of Responsible Party: _____
(If different from patient)

Date: _____

Relation To Patient: _____