Name: ____________________________ ____________________ ___________________________
(First) (Middle) (Last)

Nickname:____ **Gender**: ______ M _______ F

Date of Birth (Month/Day/Year):___________________ **Age:**_________**Soc. Sec #**: _______________________

Emergency Contact:____________________________________ ____________________________________
(Name) (Phone #)

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

Local Address: ____ _____________
(Street) (Apt, Ste, Unit)

__________________________________ ____________________ ___________________________
(City) (State) (Zip Code)

Northern Address: ____ _____________
(Street) (Apt, Ste, Unit)

__________________________________ ____________________ ___________________________
(City) (State) (Zip Code)

Email Address:____
We can send you email reminders regarding your appointment day & time. Please provide us with your email so we may help you keep track of your therapy appointments.

Phone: ____________________ ___________________________ ___________________________
(Home) (Northern Phone) (Work)

___________________________ ***NOTE***: We can send you text reminders regarding your appointment day & time.
(Cell)
Please let us know your cell phone carrier if you would like these reminders to be sent. ______________________

Marital Status: ______ Single _______ Married _______ Divorced _______ Widowed

Employer:____
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)

PATIENT SIGNATURE & ACKNOWLEDGEMENT

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 ***text messages*** regarding my treatment & appointments to be sent to the cell phone number I have provided.

_______I authorize ***email messages*** regarding my treatment, appointments, and important messages to be sent to the email address I have provided.

_______ I have read, understand, and agree to the financial policies of Medical & Sports Rehabilitation Center, Inc. (Does not apply to WC or VA patients)

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

_______I hereby instruct and direct my insurance company to pay Medical & Sports Rehabilitation Center, Inc for services received. If my current policy prohibits direct payment to the above medical provider, I also instruct and direct the check be sent to Medical & Sports Rehabilitation Center, Inc. I authorize Medical & Sports Rehabilitation Center to deposit any check that is received for my account when it is made out to me. A photocopy of the Assignment shall be considered as effective and valid as the original. (Does not apply to WC or VA patients)

_______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)

Patient's Signature: X____ Date:_______________

Signature of Responsible Party:_______________________________________ Date:_______________
(If different from patient)

Relation to Patient:____

Name:____________________________ ____________________ ___________________________
(First) (Middle) (Last)

PATIENT HEALTH HISTORY QUESTIONNAIRE

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

SOCIAL HISTORY

Primary Language:____

Occupation:____

Work Status (Please Check One):

_______ Full Time _______ Part Time _______ Self-Employed _______ Not Employed

_______ Disabled _______ Retired _______ Student

Social Activities (interests/hobbies/exercise):_______________________________________

____

Support System (who at home can help you if needed):__________________________________

Referring Physician (who sent you to therapy?):______________________________________

Primary Care Physician (if applicable):____

Next scheduled Dr Appointment (Date):____

CURRENT MEDICATIONS

Please provide us with a current list of your medications and/or herbal supplements or list them below

____ ____

____ ____

____ ____

Name:______________________________ ______________________ ______________________________

(First) (Middle) (Last)

CURRENT & PAST MEDICAL HISTORY

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______________________________

Place a "CHECK MARK" next to the condition/s that apply to you.

	Diabetes		Neurological Disorder		Anxiety
	Heart Disease		Stroke		Depression
	Pacemaker		Parkinson's		Panic Attacks
	High Blood Pressure		Epilepsy		HIV/AIDS
	Shortness of Breath		Hearing Difficulties		Hepatitis
	Lung Problems		Visual Difficulties		MRSA
	Unexplained Weight Change		Stomach or Bowel Disorders		Staph

I ______ have or I ______had CANCER (please check have or had): _________YES _______NO

Location/Body Part with Cancer:____

I am still currently being treated for cancer: _______YES _______NO

I have been diagnosed with ARTHRITIS: _______YES _______NO

Location/Body Part with ARTHRITIS:____

I have been diagnosed with OSTEOPOROSIS: _______YES _______NO

Location/Body Part with OSTEOPOROSIS:____

I have had a JOINT REPLACEMENT: _______YES _______NO

Location/Body Part of JOINT REPLACEMENT:____

Please describe any other problems not listed above:____

Name:_____________________________ _____________________ ____________________________
(First) (Middle) (Last)

KEY QUESTIONS ABOUT YOUR CONDITION

What is your **MAIN** problem?

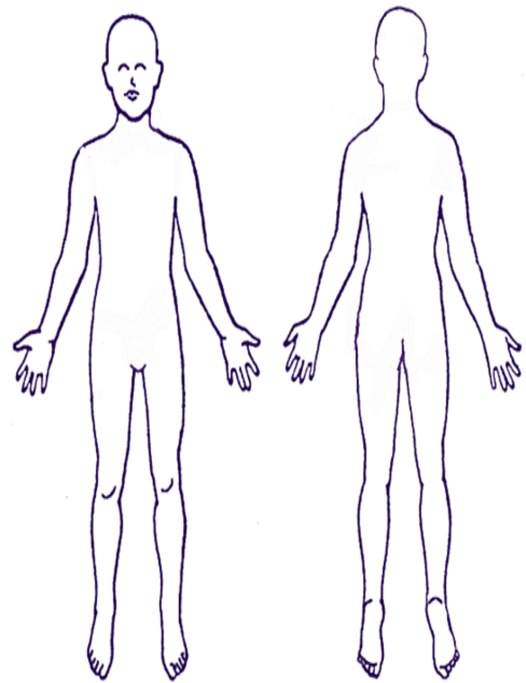
____

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 **WITH ACTIVITY**
(Zero = no pain & 10 = severe pain)

0	1	2	3	4	5	6	7	8	9	10



Place check marks on the body where you have pain or numbness.

Please indicate your present level of difficulty for each area listed below by checking the appropriate box for each activity.

	No Problems	Mild Difficulties	Moderate Difficulties	Severe Difficulties	Unable To Perform
Exercise					
Sleeping					
Sitting					
Standing (Getting up from sitting)					
Personal Care (Dressing/Bathing)					
Walking					
Lifting					
Social Life (Recreational & Social Activities)					
Traveling					