Community Rehab Physical Therapy
Patient Information Form

Patient Information				
Patient Name (Last, First, MI)	Sex	Marital Status	Date of Birth	Social Security No.
Street Address	City, State, Zip			Home Phone
Employer				Work Phone
Email Address				

Responsible Party ☐ Check if Same as Patient				
Patient Name (Last, First, MI)	Sex	Marital Status	Date of Birth	Social Security No.
Street Address	City, State, Zip			Home Phone
Employer				Work Phone
Email Address				

Additional Information		
Referring Physician (Name, Location)		
Family Physician (Name, Location)		
How did you hear about us? (Circle One)	Referring Doctor Online Friend Returning Patient Insurance Other:_____	
Emergency Contact (Name, Relationship)	Cell Phone	Work Phone

Primary Health Insurance If Insurance card is presented to staff, only the Policy Holder info is required.			
Primary Carrier Name			
ID No.	Group No.	Employer	
Policy Holder Name	Relation to Patient	Date of Birth	Social Security No.
Secondary Carrier Name (If Applicable)			
ID No.	Group No.	Employer	
Policy Holder	Relation to Patient	Date of Birth	Social Security No.

Please Check if either of the following apply:	☐ Workers' Compensation	☐ Automobile Accident

Initial:

_____I certify that the above information is correct to the best of my knowledge. I understand that I am personally responsible to pay all charges for services rendered to me and agree to make payment when due. Any billing sent by the provider to an insurance company, attorney, or other third party is for the accommodation of the patient and does not relieve the undersigned to pay charges for the services provided.

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CONSENT FOR CARE AND TREATMENT

I the undersigned, having legal authority to do so, do hereby agree and give consent for Community Rehab Physical Therapy to furnish medical care and treatment to as considered necessary and proper in diagnosing or treating my/his/her condition.

_____
Initial

BENEFIT ASSIGNMENT AND RELEASE OF INFORMATION

I hereby assign all medical benefits, including major medical benefits, Medicare, private insurance, and any other health plans to which I am entitled to Community Rehab. I hereby authorize the release of information necessary, including Medical Records to secure payment.

_____
Initial

SCHEDULING AND CANCELLATION POLICY - $25 FEE WILL BE ASSESSED FOR NO SHOW TO SCHEDULED VISIT

Community Rehab reserves the right to bill a $25 No Show fee if we are not notified that you are the unable to attend your scheduled appointment. If you cannot attend your scheduled appointment time, we ask that you notify us 24 hours prior to your appointment so we may accommodate other patients. Consistency in your treatment is important to your rehabilitation outcome and multiple cancellations may result in termination of your treatment or a loss of desired schedule time. If you arrive 15 minutes late or more, we reserve the right to reschedule your appointment.

_____
Initial

ACKNOWLEDGEMENT OF OFFER OF NOTICE OF PRIVACY PRACTICES

I certify that a copy of the Privacy Practices has been made available to me. I understand that a copy can be accessed and downloaded from www.communityrehabptcenters.com at any time.

_____
Initial

May we leave messages on your answering machine? Yes No

Please list all individuals allowed to access your health information: _____

SPECIAL BILLING CIRCUMSTANCES (Please initial next to any that apply.) I understand that I have:

_____Not provided Community Rehab with the proper referral form, referral authorization, or insurance information.

_____Voluntarily requested that Community Rehab NOT bill any insurance I have, without regard to whether these services are covered by any such insurance.

POLICY ON USE OF RECORDING DEVICES BY PATIENT IN OUR OFFICES

To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited within our offices at all locations. This includes any type of audio/video equipment or cell phones. The Health Insurance Portability and Accountability Act (HIPAA) grants privacy protection to patient records. Electronic recording infringes on the privacy rights of patients, licensed Therapists and employees. If it is discovered that you have electronically recorded any of the Community Rehab Staff or patients, you will be withdrawn from care. You are expected to abide by this policy while on our premises.

PATIENT IDENTITY

My signature below means that I have given truthful information about my name and identity.

_____

Patient Signature Date

_____

Responsible Party Signature (If other than patient) Date

Community Rehab Physical Therapy
Health History Form

Patient Name	Age	Height	Weight	Today's Date

Do you have a Pacemaker? **Yes** **No**	Do you smoke? **Yes** **No**	Are you latex sensitive? **Yes** **No**

ALLERGIES:

MEDICATIONS (INCLUDE PILLS, INJECTIONS, AND/OR SKIN PATCHES)

Have you ever taken steroid medications for any medical conditions? **Yes** **No**

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **Yes** **No**

SEIZURES, INJURIES, AND HOSPITALIZATIONS:

DIAGNOSTIC TESTS (x-ray, MRI, CT Scan, Bone Scan, blood tests, etc.)

Treatment received so far for this injury, pain, or problem:

Occupation, including activities that comprise your work day:

Are you on a work restriction from your doctor? **Yes** **No** If yes, please explain.

Leisure activities, including exercise:

WOMEN ONLY: Are you currently pregnant or think you might be pregnant? **Yes** **No**

Have you RECENTLY experienced any of the following (Check all that apply)?

☐ Fatigue	☐ Numbness or Tingling	☐ Constipation
☐ Fever/Chills/Sweats	☐ Muscle Weakness	☐ Diarrhea
☐ Nausea/Vomiting	☐ Dizziness/lightheadedness	☐ Shortness of Breath
☐ Unexpected Weight Loss/Gain	☐ Heartburn/Indigestion	☐ Fainting
☐ Difficulty with balance while walking	☐ Difficulty Swallowing	☐ Cough
☐ Falls	☐ Changes in Bowel or Bladder Function	☐ Headaches
☐ Night Pain		

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

☐ AIDS/HIV	☐ Depression	☐ Thyroid Problems
☐ Cancer	☐ Lung Problems	☐ Diabetes
☐ Heart Problems	☐ Tuberculosis	☐ Osteoporosis/Osteopenia
☐ Chest Pain/Angina	☐ Asthma	☐ Multiple Sclerosis
☐ High Blood Pressure	☐ Arthritis	☐ Epilepsy/Seizures
☐ Circulation Problems	☐ Bladder/Urinary Tract Infection	☐ Eye Problem
☐ Blood Clots	☐ Kidney Problem	☐ Ulcers
☐ Stroke	☐ Sexually Transmitted Disease	☐ Liver Problems
☐ Anemia	☐ Pelvic Inflammatory Disease	☐ Hepatitis
☐ Bone/Joint Infection	☐ Chemical Dependency	☐ Pneumonia

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Approximately what date did your symptoms start? (Include surgery date if applicable.)

What do you think caused your symptoms, injury, and/or pain? (or, No Apparent Reason)

My symptoms are currently: □ **Getting Better** □ **Getting Worse** □ **About the same**

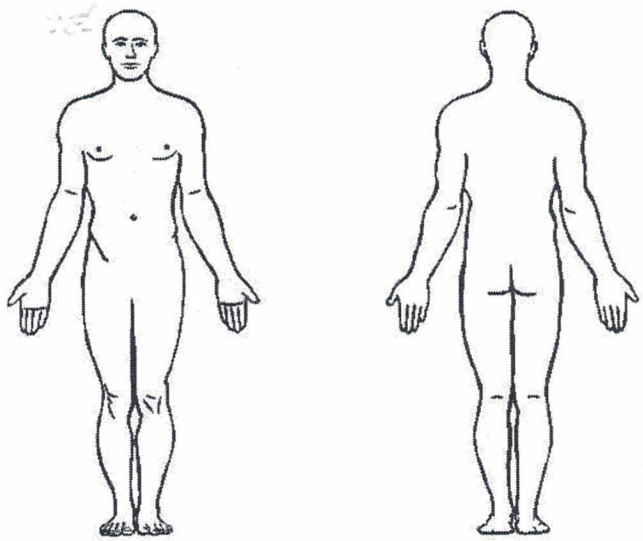
Body Chart:
Please mark the areas where you feel symptoms on the chart to the right with the following symbols to help you describe your symptoms:

↓ **Shooting/Sharp Pain**

O **Dull/Aching Pain**

X **Numbness**

= **Tingling**



My symptoms currently: □ **Come and go** □ **Are Constant** □ **Are constant, but change**

Aggravating Factors: Please *circle* any activities or factors that make your symptoms ***worse***.

Bending **Sitting/Rising** **Standing** **Walking** **Lying**

AM/ As the day progresses/ PM **When Still/ On the Move**

Symptom Relieving Factors: Please *circle* any activities or factors that make your symptoms ***better***.

Bending **Sitting/Rising** **Standing** **Walking** **Lying**

AM/ As the day progresses/ PM **When Still/ On the Move**

How are you currently able to sleep at night due to your symptoms?
□ No Problem Sleeping □ Difficulty Falling Asleep □ Awakened by Pain □ Sleep only with medication

When are your symptoms worst? □ **Morning** □ **Afternoon** □ **Evening** □ **Night** □ **After Exercise**

When are your symptoms the best? □ **Morning** □ **Afternoon** □ **Evening** □ **Night** □ **After Exercise**

Using the 1-10 scale, with 0 being *"No Pain"* and 10 being "*Emergency Room Pain,"* please describe:

No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

Your **current** level of pain while completing this survey: _____

Level of pain on your **best** day: _____

Level of pain on your **worst** day: _____

Have you ever had this injury before: Yes No When_____ Treatment Received _____