# **Patient Information**

SIGNATURE



PATIENT'S LEGAL NAME	SOCIAL SECURITY #			SEX	M F
BIRTH DATE AGE	MARITAL STATUS Married	d Single	Widowed	Divorced	Separated
MAILING ADDRESS			STATE	ZIP	
HOME #	_ WORK #	CELL#	ŧ		
Do we have permission to leave a mes	sage on your phone? Y	Ν			
Text or email appointment reminders?	Y N EMAIL				
Who can we thank for referring you to	OrthoRehab?				

## Spouse, Parent, or Legal Guardian Information & Emergency Contact info

NAME RELATION SOCIAL SECURITY #			BIRTH D	BIRTH DATE CELL #			F
		WORK #					
In case of emergency, ple	ase contact:						
HOME #	WORK #		CELL #				
Accident Insurar	nce Informatio	n					
If Accident Related:	Work Related Y	N Auto Accident	Y N	Other Accide	ent Y	Ν	
ACCIDENT INSURANCE		CLAIN	1#				
ADJUSTER'S NAME & PH							
		BE					
PRIMARY INSURANCE			DARY INSURAN	CE			
BIRTH DATE OF POLICY				HOLDER			
Additional Inform	nation						
PLACE OF EMPLOYMEN	т	OCCUP					
WORK ADDRESS							
FAMILY PHYSICIAN		REFERR	ING PHYSICIAN	1			
	default on payment of t d to the balance of said	his account and collection	agency services	are required, all c	osts of a	ollectior	including

PLEASE PRESENT YOUR PHOTO ID & HEALTH INSURANCE CARD(S) TO OUR FRONT DESK PERSONNEL

DATE

# **Medical History**



#### NAME:

AGE: \_\_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

WHAT EASES YOUR PAIN?

WHAT MAKES YOUR PAIN WORSE?

WHAT ARE YOUR GOALS IN PHYSICAL THERAPY?

#### HAVE YOU HAD PREVIOUS TREATMENT FOR THIS PROBLEM?

PLEASE SPECIFY: PT CHIROPRACTIC

#### HAVE YOU HAD ANY OF THE FOLLOWING TESTS?

X-RAY CT SCAN MRI EMG



# Please mark the areas of your pain here: Иш

Please mark any of the following past and current conditions that apply to you (be as thorough as possible):

YES	NO	CONDITION		YES	NO	CONDITION	l		YES	NO
		Dizzy Spells				MRSA				
		Emphysema/E	Bronchitis			Multiple Sclerosis		S		
		Fibromyalgia				Muscular [	Disease	9		
		Fractures				Osteoporo	osis			
		Gallbladder Pr	oblems			Parkinsons	S			
		Headaches				Rheumato	id Arth	nritis		
		Hearing Impai	rment			Seizures				
		Hepatitis				Smoking				
		High Choleste	rol			Speech Pre	oblem	S		
		High/Low Bloo	od Pressure			Strokes				
		HIV/AIDS	HIV/AIDS Thyroid Disease							
		Incontinence				Tuberculosis				
		Kidney Problems				Vision Problems				
		Metal Implants	5							
Please explain any of the above marked "Yes" and describe any additional condi- tions or precautions:										
Injury a result of a fall in the past year? YES			Have you had two or more falls in the last year? YES NO							
Please describe <b>all surgeries</b> or hospitaliza-		Please list <b>all medications</b> you are currently taking (continue on back side if necessary):								
tions (continue on back side if necessary):		MEDICATION DOSAGE FREQUENCY ROUTE REASON TAKIN				REASON TAKING				
SURGERY TYPE:DATE (mm/yyyy):										
	arked condi rear? pitaliz	arked condi- rear? YES	Image: series of the series	Dizzy Spells   Dizzy Spells   Emphysema/Bronchitis   Fibromyalgia   Fractures   Gallbladder Problems   Headaches   Hearing Impairment   Hepatitis   High Cholesterol   High/Low Blood Pressure   HIV/AIDS   Incontinence   Kidney Problems   Metal Implants	Dizzy Spells   Dizzy Spells   Emphysema/Bronchitis   Fibromyalgia   Fibromyalgia   Fractures   Gallbladder Problems   Headaches   Hearing Impairment   Hepatitis   High Cholesterol   High/Low Blood Pressure   HIV/AIDS   Incontinence   Kidney Problems   Metal Implants   arked condi-   Please list all medications you are current	Dizzy Spells     Image: Spells     Image	Dizzy Spells     MRSA       Dizzy Spells     Multiple Science       Emphysema/Bronchitis     Multiple Science       Fibromyalgia     Multiple Science       Fractures     Osteopore       Gallbladder Problems     Parkinson       Headaches     Parkinson       Hearing Impairment     Seizures       Hepatitis     Smoking       Hepatitis     Speech Pr       High/Low Blood Pressure     Strokes       HIV/AIDS     Thyroid Di       Incontinence     Tuberculor       Kidney Problems     Vision Pro       Metal Implants     Vision Pro       Please list all medications you are currently taking (continue or sary):	Dizzy Spells       MRSA         Emphysema/Bronchitis       Multiple Sclerosis         Fibromyalgia       Multiple Sclerosis         Fractures       Osteoporosis         Gallbladder Problems       Parkinsons         Headaches       Parkinsons         Headaches       Seizures         Heading Impairment       Seizures         High Cholesterol       Speech Problems         High/Low Blood Pressure       Strokes         Incontinence       Thyroid Disease         Incontinence       Thyroid Disease         Metal Implants       Vision Problems         Arked condi-       Please list all medications you are currently taking (continue on back strokes)         Please list all medications you are currently taking (continue on back strokes)	Dizzy Spells       MRSA         Emphysema/Bronchitis       Multiple Sclerosis         Fibromyalgia       Multiple Sclerosis         Fractures       Osteoporosis         Gallbladder Problems       Parkinsons         Headaches       Parkinsons         Headaches       Seizures         Headaches       Smoking         Heatring Impairment       Seizures         Hepatitis       Smoking         High Cholesterol       Speech Problems         High/Low Blood Pressure       Thyroid Disease         Incontinence       Thyroid Disease         Kidney Problems       Heat Implants         Metal Implants       Vision Problems         Please list all medications you are currently taking (continue on back side if necessary):         MEDICATION       DOSAGE       FREQUENCY	Dizzy Spells       MRSA         Emphysema/Bronchitis       Multiple Sclerosis         Fibromyalgia       Multiple Sclerosis         Fractures       Osteoporosis         Gallbladder Problems       Parkinsons         Headaches       Rheumatoid Arthritis         Heating Impairment       Seizures         Hepatitis       Speech Problems         High Cholesterol       Strokes         High/Low Blood Pressure       Thyroid Disease         Hil//AIDS       Thyroid Disease         Incontinence       Thyroid Disease         Kidney Problems       Thyroid Disease         Metal Implants       Thyroid Disease         arked condi-       NO         Please list all medications you are currently taking (continue on back side if necessary):         MetalZarany:       Dosage         Please list all medications you are currently taking (continue on back side if necessary):



#### CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPTIONS

I understand that:

- As part of my health care, Orthopedic Rehab Inc. originates and maintains health records describing my health records describing my health history, symptoms, examinations, diagnoses and treatment.
- The use and disclosure of my protected health information (PHI) by Orthopedic Rehab Inc. is necessary in order to provide my medical care, and is also necessary for Orthopedic Rehab Inc. to obtain payment for my treatment and to carry out the practice's health care operations.
- I have the option to receive a copy of **Orthopedic Rehab Inc.'s Notice** of **Privacy Practices** which provides a more complete description of the use and disclosure of my health information, and that I have the right to review that Notice prior to signing this consent. I also understand that Orthopedic Rehab Inc. reserves the right to change the Notice and its privacy practices at any time and that if I request, Orthopedic Rehab Inc. will mail me a copy of any revised Notice prior to its implementation.

I give Orthopedic Rehab Inc. permis- sion to talk to the following person/ people regarding my account and health information:
NAME:
RELATIONSHIP TO PATIENT:

## CANCELLATION AND NO SHOW POLICY

Your appointments are reserved especially for you and are very important to the OrthoRehab team. We understand that sometimes schedule changes are necessary and therefore, we respectfully request at least 24 hour notice for cancellations or rescheduling of appointments. Because of the busy nature of our office, 24 hour notice allows us time to offer your appointment to another patient.

Missed scheduled appointments, without providing 24 hour advance notice, will be charged a \$25 fee.

### ASSIGNMENT OF BENEFITS AND INSURANCE DISCLAIMER

I authorize my health insurance to make payment of medical benefits directly to Orthopedic Rehab Inc. I understand that I am liable for any charges incurred should my insurance or the liable party's insurance deny payment for ANY reason.

Although Orthopedic Rehab Inc. contracts with most insurance providers, they bill my insurance as a courtesy to me. I will provide all pertinent and related insurance information, including any accident, automobile, liability, and or health insurance. Orthopedic Rehab Inc. reserves the right to lien patient recoveries from legal or insurance settlements for unpaid charge when permitted by law. Orthopedic Rehab Inc. will not bill attorneys for any claims.

I am responsible for knowing what my medical and outpatient physical therapy benefits are. I agree to pay any co-payments, co-insurance, and deductibles at the time of service. I understand that should my balance exceed 90 days, a finance charge will begin to accrue.

Orthopedic Rehab Inc. will arrange a payment plan and/or assist me with Care Credit, when necessary. Unless payment arrangements are made with Orthopedic Rehab Inc., past due balances will be sent to an outside collections agency. I understand that should I default on payment of my account and collection agency services are required, all costs of collection including attorneys will be added to the balance of my account.



# Neck Index

#### Name:

#### Date:

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

PAIN INTENSITY	0 - I have no pain at the moment.
	1 - The pain is very mild at the moment.
	2 - The pain comes and goes and is moderate.
	3 - The pain is fairly severe at the moment.
	4 - The pain is very severe at the moment.
	5 - The pain is the worst imaginable at this moment.
PERSONAL CARE	0 - I can look after myself normally without causing extra pain.
	1 - I can look after myself normally but it causes extra pain.
	2 - It is painful to look after myself and I am slow and careful.
	3 - I need some help but I manage most of my personal care.
	4 - I need help every day in most aspects of self care.
	5 - I do not get dressed, I wash with difficulty and stay in bed.
SLEEPING	0 - I have no trouble sleeping.
	1 - My sleep is slightly disturbed (less than 1 hour sleepless).
	2 - My sleep is mildly disturbed (1-2 hours sleepless).
	3 - My sleep is moderately disturbed (2-3 hours sleepless).
	4 - My sleep greatly disturbed (3-5 hours sleepless).
	5 - My sleep is completely disturbed (5-7 hours sleepless).
LIFTING	0 - I can lift heavy weights without extra pain.
	1 - I can lift heavy weights but it causes extra pain.
	2 - Pain prevents lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table).
	3 - Pain prevents lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
	4 - I can only lift very light weights.
	5 - I cannot lift or carry anything at all.
READING	0 - I can read as much as I want with no neck pain.
	1 - I can read as much as I want with slight neck pain.
	2 - I can read as much as I want with moderate neck pain.
	3 - I cannot read as much as I want because of moderate neck pain.
	4 - I can hardly read at all because of severe neck pain.
	5 - I cannot read at all because of severe neck pain.

CONCENTRATION	0 - I can concentrate fully when I want with no difficulty.
	1 - I can concentrate fully when I want with slight difficulty.
	2 - I have a fair degree of difficulty concentrating when I want.
	3 - I have a lot of difficulty concentrating when I want.
	4 - I have a great deal of difficulty concentrating when I want.
	5 - I cannot concentrate at all.
RECREATION	0 - I am able to engage in all my recreation activities without neck pain.
	1 - I am able to engage in all my usual recreation activities with some neck pain.
	2 - I am able to engage in most but not all my usual recreation activities because of neck pain.
	3 - I am only able to engage in a few of my usual recreation activities because of neck pain.
	4 - I can hardly do any recreation activities because of neck pain.
	5 - I cannot do any recreation activities at all.
DRIVING	0 - I can drive my car without any neck pain.
	1 - I can drive my car as long as I want with slight neck pain.
	2 - I can drive my car as long as I want with moderate neck pain.
	3 - I cannot drive my car as long as I want because of moderate neck pain.
	4 - I can hardly drive at all because of severe neck pain.
	5 - I cannot drive my car at all because of neck pain.
WORK	0 - I can do as much work as I want.
	1 - I can only do my usual work but no more.
	2 - I can only do most of my usual work but no more.
	3 - I cannot do my usual work.
	4 - I can hardly do any work at all.
	5 - I cannot do any work at all.
HEADACHES	0 - I have no headaches at all.
	1 - I have slight headaches which come infrequently.
	2 - I have moderate headaches which come infrequently.
	3 - I have moderate headaches which come frequently.
	4 - I have severe headaches which come frequently.
	5 - I have headaches almost all the time.

#### NECK INDEX SCORE: \_\_\_\_\_

Index Score = [Sum of all statements selected / (# of sections with a statement selected X 5)] X 100