

## PATIENT INFORMATION

Patient's Legal Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex M F  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Marital Status: Married Single Widowed Divorced Separated  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
Do we have permission to leave a message on your phone? Yes No  
Text or email appointment reminders? Yes No Email: \_\_\_\_\_  
Have you received home health services in the last 60 days? Yes No  
List other providers you are treating with (excluding your MD): \_\_\_\_\_

## SPOUSE, PARENT/LEGAL GUARDIAN & EMERGENCY CONTACT INFORMATION

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex M F  
Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_  
In case of emergency, please contact: \_\_\_\_\_ Relationship \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

## ACCIDENT INSURANCE INFORMATION

**PLEASE COMPLETE:**    **Work Related**    Yes    No    **Auto Accident**    Yes    No    **Other Accident**    Yes    No  
Accident Insurance \_\_\_\_\_ Claim # \_\_\_\_\_  
Adjuster's Name & Phone Number \_\_\_\_\_  
Date of Accident \_\_\_\_\_ Describe \_\_\_\_\_

## HEALTH INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Subscriber's Name \_\_\_\_\_  
Birth Date of Policy Holder \_\_\_\_\_ Birth Date of Policy Holder \_\_\_\_\_

## ADDITIONAL INFORMATION

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_  
Family Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

I understand that should I default on payment of this account and collection agency services are required, all costs of collection including attorney fees will be added to the balance of said account.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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

# Medical History

**NAME:** \_\_\_\_\_

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

**WHAT EASES YOUR PAIN?** \_\_\_\_\_

**WHAT MAKES YOUR PAIN WORSE?** \_\_\_\_\_

**WHAT ARE YOUR GOALS IN PHYSICAL THERAPY?**  
\_\_\_\_\_

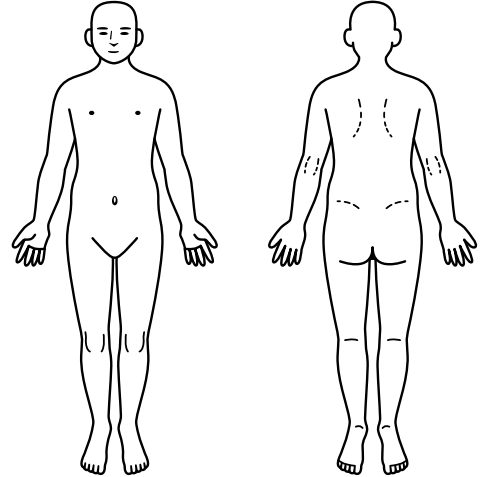
**HAVE YOU HAD PREVIOUS TREATMENT FOR THIS PROBLEM?**

PLEASE SPECIFY: PT      CHIROPRACTIC      OTHER \_\_\_\_\_

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

X-RAY      CT SCAN      MRI      EMG

**Please mark the areas of your pain here:**



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

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Allergies			Dizzy Spells			MRSA		
Anemia			Emphysema/Bronchitis			Multiple Sclerosis		
Anxiety			Fibromyalgia			Muscular Disease		
Arthritis			Fractures			Osteoporosis		
Asthma			Gallbladder Problems			Parkinsons		
Autoimmune Disorder			Headaches			Rheumatoid Arthritis		
Cancer			Hearing Impairment			Seizures		
Cardiac Conditions			Hepatitis			Smoking		
Cardiac Pacemaker			High Cholesterol			Speech Problems		
Chemical Dependency			High/Low Blood Pressure			Strokes		
Circulation Problems			HIV/AIDS			Thyroid Disease		
Currently Pregnant			Incontinence			Tuberculosis		
Depression			Kidney Problems			Vision Problems		
Diabetes			Metal Implants					

Please explain any of the above marked "Yes" and describe any additional conditions or precautions:

Injury a result of a fall in the past year?    YES                      NO                      Have you had two or more falls in the last year?    YES                      NO

Please describe **all surgeries** or hospitalizations (*continue on back side if necessary*):

**SURGERY TYPE:**                      **DATE (mm/yyyy):**

Please list **all medications** you are currently taking (*continue on back side if necessary*):

MEDICATION	DOSAGE	FREQUENCY	ROUTE	REASON TAKING

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

## 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 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. permission to talk to the following person/people regarding my account and health information:***

NAME:

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RELATIONSHIP TO PATIENT:

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## 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.

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**PATIENT OR GUARANTOR SIGNATURE**

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**DATE**

**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