

**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?**  
\_\_\_\_\_

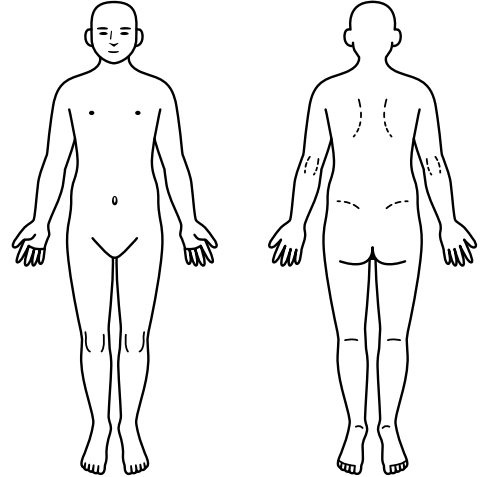
**HAVE YOU HAD PREVIOUS TREATMENT FOR THIS PROBLEM?**

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**

## Vestibular Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Onset date of symptoms \_\_\_\_\_

**Symptoms related to current condition (check all that apply)**

Headache	Trouble falling asleep	Irritability
Nausea	Excessive sleep	Sadness
Vomiting	Loss of sleep	Nervousness
Balance issues	Drowsiness	More emotional
Dizziness	Light Sensitivity	Numbness
Fatigue	Sound sensitivity	Feeling "slow"
Feeling "foggy"	Difficulty concentrating	Difficulty remembering
Visual problems	Hearing loss	Ears ringing
Neck pain		

**Symptoms increase with (check all that apply)**

Rolling in bed	Turning in bed	Walking	Straining
Reading	Lying down to sitting up	Looking up	Looking down
Lying down	Loud noises	Sit to stand	Bending/squatting
Driving	Coughing/sneezing	Other	

How long do symptoms last?    <1 min    <30 min    Hours    Constant

Have you been treated for this issue prior?    Y    N    If yes, by whom \_\_\_\_\_

Are you taking prescription or over the counter medications for this issue?    Y    N

Are you using an assistive device due to this issue (walker, cane, wheelchair, etc.)?    Y    N

Is there anything else you would like your physical therapist to know about your condition?

\_\_\_\_\_