Pro Rehab
We appreciate the opportunity to serve your physical therapy needs.

PATIENT INFORMATION

Name: (First MI Last) _____ Sex: ☐ M ☐ F Birthday _____/_____/_____

Address: _____City _____ST_____ ZIP_____

Phone_____ Secure to leave Voice mail ☐Yes ☐No

Email: _____(Used for statements, survey and newsletters)

SSN _____-_____-_____ or provide driver's License Marital Status S M W D

How did you hear about us: ☐Physician ☐Insurance ☐Internet ☐Former Patient ☐Other _____

If under 18 parent Name :_____

PHYSICIAN INFORMATION

Ref. Clinician: _____ Phone:_____ Fax:_____

EMPLOYER & INSURANCE INFORMATION

Employer at time of Injury: _____Phone # _____

Employer's Address (Street. City, State, Zip)_____

Date of Injury _____ Occupation::_____

WC Insurance_____

Address:_____

Claim # _____ Claim Representative _____

Phone # _____ Ext. _____ Fax _____

Utilization Review Company_____ Claim Representative _____

Phone # _____ Ext. _____ Fax _____

ATTORNEY INFORMATION

Name of Attorney: _____ Phone: _____

Address:_____

AUTHORIZATION TO RELEASE INFORMATION ● ASSIGNMENT OF BENEFITS ● AGREEMENT / CONTRACT

I hereby authorize Pro Rehab, INC. to release to the insurance company(s) and /or attorney named above any information acquired in the course of my examination or treatment (if patient is a minor, parent or guardian sign).

I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign to Pro Rehab, Inc. any and all insurance and settlement benefits due me to the full extent of my financial obligation to said clinic.

I understand my insurance coverage is a relationship between myself and my insurance company and I agree to accept financial responsibility for payment for charges incurred

PRO REHAB, Inc.

Name:_____

Are You: ☐Right-handed ☐Left-handed

Race:

☐ American Indian or Alaska Native
☐ Asian
☐ African American
☐ Hispanic or Latino
☐ Native Hawaiian or Pacific Islander
☐ White

Language:
☐ English understood
☐ Interpreter needed
☐ Language you speak often:

_____

SOCIAL HISTORY

Cultural/Religious:
Any customs or religious beliefs or wishes that might affect care?

_____

With whom do you live:
☐ Alone ☐ Spouse only
☐ Spouse and other(s) only ☐Child (not spouse)
☐ Other relative(s) ☐Group setting
☐ Personal care attendant
☐ Other:_____

Employment/Work (Job/School/Play):
☐ Working full-time in home
☐ Working part-time out of home
☐ Working full-time out of home
☐ Working part-time from home
☐ Homemaker
☐ Student
☐ Retired
☐ Unemployed
☐ Occupation:

_____

LIVING ENVIRONMENT

Does your home have
☐ Stairs, no railing
☐ Stairs, railing
☐ Ramps
☐ Elevator
☐ Uneven terrain
☐ Assistive devices(eg, bathroom):_____
☐ Any obstacles:

Do you Use
☐ Cane
☐ Walker or rollator
☐ Man. wheelchair
☐ Mot. wheelchair
☐ Glasses, hearing aids
☐ Other:

_____

Where do you live:
☐ Private home
☐ Private apartment
☐ Rented room
☐ Board and care/assisted living/group home
☐ Homeless (with or without shelter)
☐ Long-term care facility (nursing home)
☐ Hospice
☐ Other:

_____

GENERAL HEALTH STATUS

Please rate your health:
☐Excellent ☐Good ☐Fair ☐Poor
Have you had any major life changes during past year? (eg, new baby, job change, death of a family member) ☐ Yes ☐No

SOCIAL/HEALTH HABITS (Past and Current)

Smoking
Currently smoke tobacco? ☐ Yes ☐No
If yes # of packs per day ____
Smoked in past?
☐ Yes year quit _____ ☐No

Alcohol
If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have, on an average week? ____

Exercise
Do you exercise beyond normal daily activities and chores? ☐ No ☐ Yes Describe the exercise:

_____

On average, how many days per week do you exercise or do physical activity? _____
For how many minutes, on an average day? ____

FAMILY HISTORY

Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather has had any of the following conditions, with age of onset if known:
Heart disease _____
Hypertension_____
Stroke _____
Diabetes_____
Cancer_____
Psychological_____
Osteoporosis: _____
Other:_____

PRO REHAB, Inc.

Medical/Surgical History:
Please check if you have ever had:

- ☐ Arthritis
- ☐ Fractures
- ☐ Osteoporosis
- ☐ Blood disorders
- ☐ Circulation problems
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Lung problems
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Parkinson disease
- ☐ Seizures/epilepsy
- ☐ Allergies
- ☐ Developmental or growth problems
- ☐ Thyroid problems
- ☐ **PACE MAKER**
- ☐ Stroke
- ☐ Diabetes
- ☐ Low blood sugar
- ☐ Head injury
- ☐ Infectious disease (eg, tuberculosis, hepatitis)
- ☐ Cancer
- ☐ Kidney problems
- ☐ Repeated infections
- ☐ Ulcers/stomach problems
- ☐ Skin diseases
- ☐ Depression
- ☐ Other:_____

Within the past year, have you had any of the following symptoms:

- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Cough
- ☐ Hoarseness
- ☐ Shortness of breath
- ☐ Dizziness or blackouts
- ☐ Coordination problems
- ☐ Weakness in arms/legs
- ☐ Loss of balance
- ☐ Difficulty walking
- ☐ Joint pain or swelling
- ☐ Pain at night
- ☐ Difficulty sleeping
- ☐ Loss of appetite
- ☐ Nausea/vomiting
- ☐ Difficulty swallowing
- ☐ Bowel problems
- ☐ Weight loss/gain
- ☐ Urinary problems
- ☐ Fever/chills/sweats
- ☐ Headaches
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Other:_____

Have you ever had surgery? ☐ Yes ☐ No

If yes, please describe, and include dates:

_____

_____

_____

For men only: Have you been diagnosed with prostate disease? ☐ Yes ☐ No

For women only: Have you been diagnosed with:

- Pelvic inflammatory disease? ☐ Yes ☐ No
- Endometriosis? ☐ Yes ☐ No
- Trouble with your period? ☐ Yes ☐ No
- Complicated pregnancies/deliveries? ☐ Yes ☐ No
- Are you pregnant, or think you might be pregnant? ☐ Yes ☐ No
- Other gynecological difficulties? ☐ Yes ☐ No

If yes, please describe:

CURRENT CONDITION(S)/CHIEF COMPLAINTS
Describe the problem(s) for which you seek physical therapy:_____

_____

How are you taking care of the problem(s) now?

_____

What are your goals for physical therapy?

_____

Are you seeing anyone else for the problem(s)?

- ☐ Acupuncturist
- ☐ Cardiologist
- ☐ Chiropractor
- ☐ Dentist
- ☐ Family practitioner
- ☐ Internist
- ☐ Massage therapist
- ☐ Neurologist
- ☐ Occupational therapist
- ☐ Orthopedist
- ☐ Osteopath
- ☐ Pediatrician
- ☐ Podiatrist
- ☐ Primary care physician
- ☐ Rheumatologist
- ☐ Other: _____

FUNCTIONAL STATUS/ACTIVITY LEVEL:
Difficulty with locomotion/movement:

- ☐ bed mobility
- ☐ transfers (such as moving from bed to chair, from bed to commode)
- ☐ gait (walking) ☐ on level ☐ on stairs ☐ on ramps ☐ on uneven terrain
- ☐ Difficulty with self-care (bathing, dressing, eating, toileting)
- ☐ Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)
- ☐ Difficulty with community and work activities integration: ☐ work/school ☐ recreation or play activity

MEDICATIONS Do you take any prescription medications? ☐ Yes ☐ No
If yes, please list:_____

_____

_____

Do you take any nonprescription medications?

_____

OTHER CLINICAL TESTS — Within the past year, have you had any of the following tests?

- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood tests
- ☐ Bone scan
- ☐ Bronchoscopy
- ☐ CT scan
- ☐ Doppler ultrasound
- ☐ Echocardiogram
- ☐ EEG (electroencephalogram)
- ☐ EKG (electrocardiogram)
- ☐ EMG(electromyogram)
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ NCV (nerve conduction velocity)
- ☐ Pap smear
- ☐ Pulmonary function test
- ☐ Spinal tap
- ☐ Stool tests
- ☐ Stress test
- ☐ X-rays

Other_____

Pro Rehab, Inc.

Clinic Policy

Welcome to Pro Rehab Inc. physical therapy clinic. Our staff is dedicated to providing quality care to all patients and we will do our best to help achieve your treatment goals.

Physical therapy is a health profession that utilizes the application of scientific principles for the identification, prevention, and rehabilitation of acute or prolonged physical dysfunction, thus, promoting optimal health and function.

Our experienced clinicians will evaluate you and will discuss with you about your condition as well as how physical therapy treatment could improve your symptoms and decrease your dysfunction.

To maximize benefits from your physical therapy treatment good attendance is necessary. Additionally, good attendance is a sign of respect towards your physical therapists and help us provide efficient and cost effective treatment. Therefore, if you need to cancel we expect notification 24 hours prior to your appointment; otherwise we reserve the right to charge you $40 for your missed visit.

If your treatment is related to an injury or accident which involves legal proceedings , special payment arrangements must be made. Please discuss this with the receptionist at the beginning of your treatment.

Please inform us immediately if there are any changes in your insurance coverage and/or home address and telephone number while you are receiving treatment.

I have received a copy of the above information and I agree to the terms listed.

_____ _____

Name Date