ProRehab
Physical Therapy

First Name:_____ MI: _____ Last: _____

Address:_____ City:_____ State:_____ Zip:_____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

SSN: _____ Email Address:_____

Employer:_____ Employer Phone: _____

Who is your General Physician: _____

Emergency Contact Person Name: _____

Emergency Contact Person Phone: _____

Please fill out the following information if different from above:

Primary Insurance:_____ Policy Holder Name:_____ Group Policy #:_____

Relationship to Patient: _____ Policy Holder ID #: _____ Date of Birth: _____

Secondary Insurance: _____ Policy Holder Name:_____ Group Policy #:_____

Relationship to Patient: _____Policy Holder ID #: _____ Date of Birth:_____

Is this work related? ☐ Yes ☐ No If yes, date of injury: _____

Is this related to a Motor Vehicle Accident? ☐ Yes ☐ No If yes, date of injury: _____

How did you hear about us? ☐ Physician Referral ☐ Family or Friends ☐ Industry

☐ Advertisement (please list form): _____ ☐ Other (please list): _____

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is $25. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment. Any future appointments may be automatically cancelled and 2 "no show" appointments may result in discharge from physical therapy. NON-SUFFICIENT FUNDS: Checks returned for Non-Sufficient Funds may be subject to a $25 processing fee.

I hereby give consent for treatment for myself, or the named minor child, by the staff at ProRehab and/or as directed by my referring physician.

I authorized the release of any information necessary to process claims for these services. I authorize release of clinical information for treatment, payment and healthcare operations.

I assign medical benefits payable for these services directly to ProRehab.

I understand that I am responsible for payment of any applicable co-payments, co-insurance and deductibles at the time of service. In signing this form I understand that I am responsible for the bill not paid my insurance carrier.

Legal Guardian Signature/Relationship:_____ **Date:**_____

_____
Patient Initial

I have been given the Notice of Privacy Practice, AND have been made aware, and copies available to me of the rights. If I have any questions I can contact the Compliance Officer at 812.759.7455.

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Medical History and Previous Treatment Form

Patient Name: _____

Please check if you have been diagnosed with any of the following conditions:

_____ Diabetes (I/II)	_____ Heart Disease	_____ High Blood Pressue	_____ Cancer
_____ Pacemaker	_____ Stroke (TIA or CVA)	_____ Seizures	_____ Metal Implants
_____ Back Pain	_____ Circulatory Problems	_____ Osteoporosis	_____ Stomach Ulcers
_____ Broken Bones	_____ Respiratory Problems	_____ Depression	_____ Kidney Disease
_____ Blood Clots	_____ Rheumatoid Arthritis	_____ Thyroid Problems	

_____ Infectious Diseases (HIV, Hepatitis B, Hepatits C, TB, etc.) _____

Other: _____

Surgical History:

During the past month have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

During the past month have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Please list all medications you are currently taking (prescribed and over the counter): _____

_____

Have you recently noted:

☐ Yes ☐ No	Weight Loss/Gain	☐ Yes ☐ No	Nausea/Vomiting
☐ Yes ☐ No	Dizziness/Lightheadedness	☐ Yes ☐ No	Unusual Weakness
☐ Yes ☐ No	Fever/Chills/Sweats	☐ Yes ☐ No	Visual Problems
☐ Yes ☐ No	Incontinence	☐ Yes ☐ No	Hearing Problems
☐ Yes ☐ No	Bleeding	☐ Yes ☐ No	Pregnant or think you may be pregnant
☐ Yes ☐ No	Speech Difficulty	☐ Yes ☐ No	Loss of Balance

Date of onset of current symptom/injury: Month: _____ **Day:** _____ **Year:** _____

Have you had the same or a similar problem in the past? ☐ Yes ☐ No

If yes, please explain: _____

Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications etc. _____

Have you received X-rays, MRI, CT scan, Bone Scan, etc for this problem? _____

Has your doctor discussed your medical findings or given you a diagnosis? ☐ Yes ☐ No

If yes, what were the findings? _____

Do you require this therapy to return to prior level of function? ☐ Yes ☐ No

What are your goals for recover? _____

Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No

If yes, plese tell us what it is: _____

Do you have any allergies? ☐ Yes ☐ No If yes, please list: _____

To the best of my knowledge the above information is accurate and complete.

Signature: _____ Date: _____

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Name: _____ Date: _____

Account Number: _____

Name of Medication		Dosage	Frequency	Route Taken (please mark X)			
				By mouth	IM	IV	Other
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

Patient Refused: _____ Date: _____

(Please Initiatl)