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.

CONTACT INFORMATION: By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

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)