ProRehab
Physical Therapy

First Name: ______ MI: ______ Last: ______

Address: ______ City: ______ State: ______ Zip: ______

Date of Birth: ______ Home Phone: ______ Cell Phone: ______

Which phone is your primary? ☐ Home ☐ Cell How do you prefer to have reminders sent? ☐ Phone call ☐ Text ☐ Email

SSN: ______ Email Address: ______

Employer: ______ Employer Phone: ______

General Physician: ______ Referring Physician: ______

Emergency Contact Name: ______ Relationship: ______

Emergency Contact Phone: ______

Please fill out the following information:

Primary Insurance: ______ Policy Holder Name: ______ Date of Birth: ______

Relationship to Patient: ______ Policy ID #: ______ Group #: ______

Secondary Insurance: ______ Policy Holder Name: ______ Date of Birth: ______

Relationship to Patient: ______ Policy ID #: ______ Group #: ______

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 ☐ Social Media

☐ 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 a subject to a $25 processing fee.

Employee Initial: ______ Patient Initial: ______

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 authorize the release of any information necessary to process claims for these services. I authorize the 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-payment, co-insurance, and deductibles at the time of service. In signing this form I understand that I am responsible for the bill not paid by my insurer

Patient/Guardian Signature: ______ 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.

Medical History and Previous Treatment

Patient Name: ____

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

_____ Diabetes	_____ Heart disease	_____ High blood pressure	_____ Cancer
_____ Pacemaker	_____ Stroke (TIA or CVA)	_____ Seizures	_____ Metal implants
_____ Back pain	_____ Circulation problems	_____ Osteoporosis	_____ Stomach ulcers
_____ Broken bones	_____ Respiratory problems	_____ Depression	_____ Kidney disease
_____ Blood clots	_____ Rheumatoid arthritis	_____ Thyroid problems	

_____ Infectious diseases (HIV, Hepatitis B, Hepatitis 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? (Circle YES or NO)

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 might be pregnant
YES	NO	Speech difficulty	YES	NO	Loss of balance

Date of onset of current symptoms/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? ____

If yes, what is the doctor's name? ____

Do you require this therapy to return to prior level of function? ☐ YES ☐ NO

What are your goals for recovery? ____

Are you aware of any physical reason why you should not receive treatment? ☐ YES ☐ NO

If yes, please 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: ________________