ProRehab
Physical Therapy

First Name: _____ MI: _____ Last Name: _____

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

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

Which phone is 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: _____ 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: Check 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 as 812.759.7455

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MEDICAL HISTORY FORM

PATIENT NAME: _____ Acct#: _____

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

_____Diabetes(I/II)	_____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	_____Asthma
_____Blood Clots	_____Rheumatoid Arthritis	_____Thyroid Problems	_____Kidney problems

_____Infectious Diseases (HIV, Hepatitis, TB, etc.) _____

_____Other: _____

Surgical History: _____

Have you recently noted? Check all that apply:

_____Nausea/Vomiting	_____Dizziness spells	_____Pain at night	_____Currently pregnant
_____Unusual weakness	_____Visual problems	_____Heart Palpitations	_____Hearing problems
_____Bleeding	_____Difficulty walking	_____Joint pain or swelling	_____Fever/chills/sweats
_____Chest Pain	_____Shortness of breath	_____Incontinence	_____Productive/Chronic Cough
_____Difficulty sleeping	_____Loss of Appetite	_____Unexplained weight changes	_____Fatigue or myalgia

Have you recently traveled out of the country? ☐ Yes ☐ No

Have you had direct prolonged contact with someone with confirmed case of coronavirus? ☐ Yes ☐ No

How many times have you fallen in the past 12 months? _____ Did it result in an injury? ☐ Yes ☐ No

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

Please list all, both prescribed and over the counter medications you are currently taking, include name, dosage, frequency, route taken:

_____

_____

_____

Sex: ☐ Male ☐ Female **Height:** _____ **Weight:** _____

Are you: ☐ Right handed ☐ Left handed

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

With whom do you live:

☐ Alone ☐ Spouse only ☐ Spouse and others ☐ Child ☐ Other _____

Where do you live:

☐ Private home ☐ Apartment/rented room ☐ Assisted living/group home ☐ Hospice ☐ Other_____

Does your home have:

☐ Stairs, no railing ☐ Stairs, railing ☐ Ramps ☐ Uneven terrain

Please explain: _____

Employment/Work (Job/School/Play):

☐ Working: ☐ Full time ☐ Part time ☐ Retired ☐ Unemployed ☐ Occupation: _____

PATIENT NAME: _____

General Health Status, Please rate your health; ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of onset of current symptoms/injury: Month _____ Day _____ Year _____

Describe the problem(s) for which you seek therapy: _____

_____

Explain how problem(s) occurred: _____

_____

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

What makes the problem(s) <u>better</u>? _____

What makes the problem(s) <u>worse</u>? _____

What functions could you perform before, that now you are unable to do? _____

_____

What are your goals for therapy? _____

Have you ever had the problem(s) before? _____

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? If so, what were the results

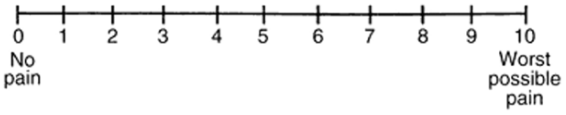
_____

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

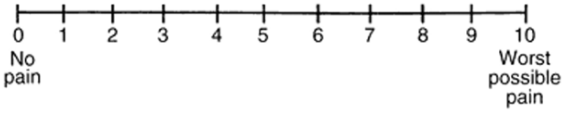
If yes, please tell us what it is: _____

Pain Rating:
If you have pain, what is your pain level? Circle

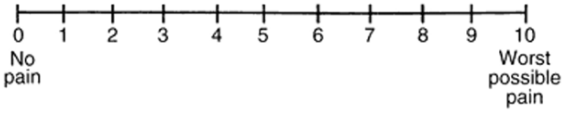
<u>CURRENT</u> Pain



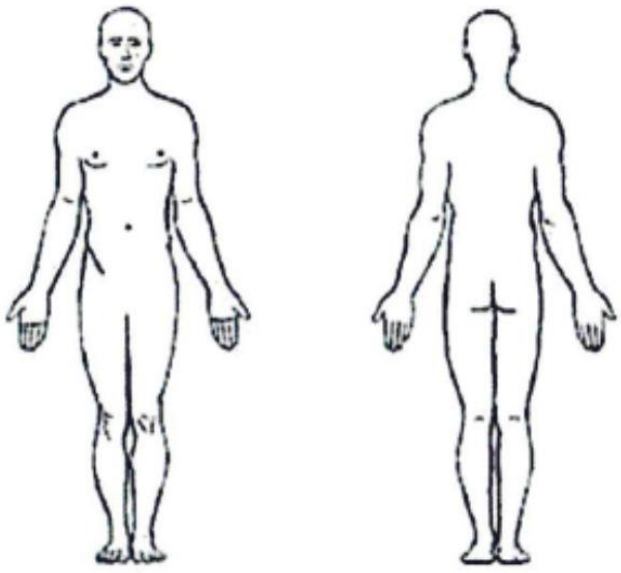
Pain level at **<u>BEST</u>**



Pain level at **<u>WORST</u>**



<u>Please mark the location of pain with an "X"</u>



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

Signature: _____ **Date:** _____

Therapist signature: _____ Date: _____