ADVANCED PHYSICAL THERAPY & REHAB - Confidential Medical History/Evaluation

Name: _____ **Date:** ___/___/___ **Referring MD:** _____

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

Cell Phone: _____ **Home Phone** _____

Email_____ **Your next appointment date with referring physician:** _____

Occupation:_____ **Is this injury?** **Work Related** **Auto Accident**

Chief Complaint: _____ **Date of Injury:** _____

Current Symptoms: **Pain** **Numbness** **Stiffness** **Weakness** **Condition:** **New** **Acute** **Chronic**

List any/all medications you are currently taking: _____

Are you allergic to anything and/or medications? _____

List any surgeries: _____

Have you had any Diagnostic or Rehabilitative Services for this Injury? **MRI** **X-rays**

Do you have any of the following?

	YES	NO
Asthma, Bronchitis or Emphysema	___	___
Shortness of Breath/Chest Pain	___	___
Coronary Heart Disease	___	___
Do you have a Pacemaker	___	___
High Blood Pressure	___	___
Heart Attack/Surgery	___	___
Stroke/TIA	___	___
Blood Clot/Emboli	___	___
Epilepsy/Seizures	___	___
Thyroid Trouble/Goiter	___	___
Anemia	___	___
Infectious Disease	___	___
Diabetes	___	___
Cancer or Chemo/Radiation	___	___
Arthritis/Swollen Joints	___	___
Osteoporosis	___	___
Varicose Veins	___	___
Gout	___	___
Sleeping Difficulties	___	___
Emotional/Psychological Problems	___	___
Bowel or Bladder Problems	___	___
Severe/Frequent Headaches	___	___
Vision/Hearing Difficulties	___	___
Dizziness or Faintness	___	___
Are you pregnant?	___	___
Smoking	Daily _____	Weekly _____
Alcohol Consumption	Daily _____	Weekly _____

Pain when performing the following activities?

	Mild	Moderate	Severe	Unable
Bending	___	___	___	___
Care for Infirm Family	___	___	___	___
Carrying Groceries	___	___	___	___
Change Pos (Sit to Stand)	___	___	___	___
Climb Stairs	___	___	___	___
Driving	___	___	___	___
Extended Computer Use	___	___	___	___
Feeding (Self)	___	___	___	___
Household Chores	___	___	___	___
Kneeling	___	___	___	___
Lift Children	___	___	___	___
Lifting	___	___	___	___
Pet Care	___	___	___	___
Reading (Concentration)	___	___	___	___
Self Care-Bathing	___	___	___	___
Self Care-Dressing	___	___	___	___
Self Care-Shaving	___	___	___	___
Sexual Activities	___	___	___	___
Sleep	___	___	___	___
Sitting (Prolonged)	___	___	___	___
Standing (Prolonged)	___	___	___	___
Walking	___	___	___	___
Yard Work	___	___	___	___

Sports _____

Recreational Activities _____

Exercise Daily _____ Weekly_____

Other Medical Conditions_____

_____

Are you aware of your Diagnosis? YES ___ NO ___ **Are you aware of your Prognosis? YES ___ NO ___**

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Universal Rehab Services Inc._regardless of anticipati out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred

Patient/Parent/Guardian Signature:_____ Date:_____

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time

Patient/Parent/Guardian Signature:_____ Date:_____

ADVANCED PHYSICAL THERAPY & REHAB

PATIENT REGISTRATION FORM

Patient Name: _____ Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ Sex: M / F (Circle one) Married/Single/Divorced/Widow

Employer Name: _____Employer Phone Number: (_____) _____

Employer Address: _____

How did you hear about our Practice? _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____ - _____ - _____

- **Must list Policy holder's name**

Relationship to Patient: (please circle one): self, spouse, or parent Date of Birth: _____/_____/_____

Address: _____ Phone Number: _____

Employer Name: _____ Employer Phone Number: (___) _____

Employer Address: _____

Who to call for an emergency:

Name: _____ Address: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____-_____ Relationship: _____

PRIMARY INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____ - _____ - _____

Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

SECONDARY INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____ - _____ - _____

Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Advanced Physical Therapy & Rehab. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____