Rehab Etc. Inc. Patient Registration Form

Patient's Last Name: _____ First Name: _____ Gender Female

(If patient is a minor) Responsible party's name: _____ Responsible party's phone #: _____

Address: _____ City _____ State: _____ Zip: _____

Cell: _____ Home: _____ Work: Email: _____

Patient's DOB: _____ Patient's Social Security #: _____

Emergency Contact: Name: _____ Relationship: _____ Phone: _____

SCRIPT FROM DOCTOR				DIRECT ACCESS				
New Patient	**New Patient** -Other (Location, friend, etc)	**Resume < 1 year**	**Resume > 1 year**	**New Patient** (by family/ friend)	**New Patient**- Other (Location, website, etc)	**Resume < 1 year**	**Resume > 1 year**	**Medicare?**

Referring Physician: _____ Physician's phone #: _____

Treatment Frequency/Duration: _____ X/Week for _____ week(s)

Chief Complaint/Diagnosis: _____ Is pain: Acute ☐ or Chronic ☐

APPT Date: _____ **Time:** _____ **Therapist:**

Insurance/Guarantor Information Primary Insured Last Name: _____ First Name: _____

DOB: *(for primary insured)* _____ Primary's Social Security #: _____ Insurance Co: _____

Group #: _____ ID #: _____ Insurance Phone #: _____

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

Precert Phone/Fax #: _____ Percert #: _____ # of visits: _____ Exp Date: _____

Eff. Date: _____ Policy Calendar Year? Yes ☐ No ☐ From _____ to _____

PPO DED: _____ Amt. Met: _____ PPO/OOP: _____ Amt. Met: _____ PPO% _____

NPPO DED: _____ Amt. Met: _____ NPPO/OOP: _____ Amt. Met: _____ NPPO%: _____

Authorized by: _____ Exclusions/Comments: _____ **Ins. Copay** _____

SECONDARY Insurance Information Primary Insured Last Name: _____ First Name: _____

DOB: *(for primary insured)* _____ Primary's Social Security #: _____ Insurance Co: _____

Group #: _____ ID #: _____ Insurance Phone #: _____

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

Precert Phone/Fax #: _____ Percert #: _____ # of visits: _____ Exp Date: _____

Eff. Date: _____ Policy Calendar Year? Yes ☐ No ☐ From _____ to _____

PPO DED: _____ Amt. Met: _____ PPO/OOP: _____ Amt. Met: _____ PPO% _____

NPPO DED: _____ Amt. Met: _____ NPPO/OOP: _____ Amt. Met: _____ NPPO%: _____

Authorized by: _____ Exclusions/Comments: _____ **Ins. Copay** _____

PATIENT MEDICAL HISTORY

To ensure you receive a complete and thorough evaluation, please provide your therapist with the following information to the best of your ability.

DATE: _____ NAME:_____ Date of Birth: _____

How did you hear about Rehab Etc.? _____

Please describe how your **CURRENT** symptoms began (i.e. bending, lifting, accident, not sure, etc):
_____
_____

Are your symptoms the result of a work injury or a motor vehicle accident? Yes ☐ No ☐

If Yes, Please explain: _____

Have you contacted a lawyer regarding your symptoms/injury? Yes ☐ No ☐

If Yes, who have you contacted? _____

When did your **CURRENT** symptoms begin? _____

What is your occupation? _____

What types of activities do you perform at work? _____
_____

Are you on restricted duty or off work as a result of your symptoms or injury? Yes ☐ No ☐

If Yes, please explain: _____
_____

Please list what activities, positions, or other factors increase your symptoms. _____
_____

Please list factors that decrease your symptoms: _____

Please list the special tests or radiology you have had with results. _____
_____

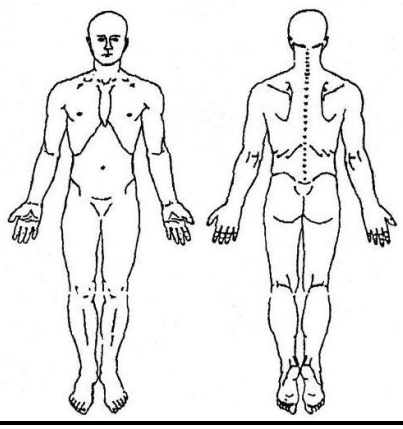
Place a mark on the line indicating your current pain rating (0 = No Pain, 10 = Emergency Room Pain)

0_____**10**

Rate your pain out of 10

10 /10 Symptoms at their best
10 /10 Symptoms at their worst

Please use the following symbols on the diagram below to indicate the type and location of your symptoms.
Pain: XXXX Numbness: ////// Tingling: OOOOO



Please check any of the following that describes your pain:

_____ Constant _____ Intermittent

_____ Sharp _____ Dull

_____ Improving _____ Worsening

_____ Disturbs sleep _____ Increases with cough/sneeze

Have you ever been diagnosed with any of the following conditions?

___ Cancer	___ Heart problems	___ Kidney problems
___ High blood pressure	___ Circulation problems	___ Asthma
___ Stomach ulcers	___ Chemical dependency	___ Thyroid problems
___ Diabetes	___ Multiple sclerosis	___ Rheumatoid arthritis
___ Other arthritic conditions	___ Depression	___ Hepatitis
___ Tuberculosis	___ Stroke	___ Blood Clots
___ Osteoporosis/Osteopenia	___ Other _____	
___ TMJ		

List any RECENT or MAJOR surgeries including the date.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

List prescription or over the counter medication, as well as vitamins/supplements you are taking.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

List any drug allergies you are aware of: _____

Are you allergic to latex? YES ☐ NO ☐

Do you smoke or use other tobacco products? YES ☐ NO ☐

If yes, how much per day? _____ For how long? _____

If you drink alcohol, about how many drinks do you consume, on average, per week? _____

Please check any of the following that you have experienced:

___ rapid weight loss/gain	___ swelling	___ nausea/vomiting
___ easy bruising	___ dizziness or balance problems	___ excessive bleeding
___ excessive fatigue	___ difficulty breathing	___ unusual weakness
___ persistent cough	___ fever/chills/night sweats	___ numbness/tingling
___ rapid heartbeat	___ tremors	___ difficulty swallowing
___ seizures	___ heartburn/indigestion	___ double vision
___ constipation/diarrhea	___ problems with vision	___ blood in stools or urine
___ unusual eye redness	___ post-menopausal	___ skin rash
___ difficulty urinating	___ difficulty sleeping	___ urinary incontinence
___ sexual difficulties	___ pregnant	___ difficulty hearing
___ headaches	___ pain which does not improve at rest	___ TMJ

Patient signature: _____ Date: _____

Therapist signature: _____ Date: _____