



First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_ SS number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Please check all the ways we can contact you

Home phone: \_\_\_\_\_  Cell phone: \_\_\_\_\_  Work phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Please keep in mind that communications via email over the internet is not a secure form of communication.

Employer and Employer phone number: \_\_\_\_\_

Who is your General Physician: \_\_\_\_\_

2<sup>nd</sup> contact person name/address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relation: \_\_\_\_\_

**Please Fill Out The Following Information If Different From Above**

Primary  
Policy holder information: \_\_\_\_\_  
(name, address, Insurance plan name)

Policy holder DOB: \_\_\_\_\_ ID/SS#: \_\_\_\_\_ Group number: \_\_\_\_\_

Secondary  
Policy holder information: \_\_\_\_\_  
(name, address, Insurance plan name)

Policy holder DOB: \_\_\_\_\_ ID/SS#: \_\_\_\_\_ Group number: \_\_\_\_\_

**Is this work related?** Yes No **If yes, Date of Injury:** \_\_\_\_\_

Employer address: \_\_\_\_\_

**Is this Motor Vehicle Accident related?** Yes No **If yes, State** \_\_\_\_\_ **and Date of accident:** \_\_\_\_\_

**How did you hear about us?**  Physician Referral, who referred \_\_\_\_\_  Family or Friend

Industry  Advertisement (please list) \_\_\_\_\_  Other (please list) \_\_\_\_\_

I hereby authorize and consent to treatments/services for myself, or on the behalf of the above named patient, performed by the staff at ProRehab and/or as directed by my referring physician.  
I assign medical benefits payable for these services directly to ProRehab. I authorize the release of any medical or other information necessary to process claims for these services.  
In Medicare assigned cases, ProRehab participates in the Medicare program and accepts Medicare's allowed amount for covered services, less any co-pay, co-insurance, deductible or non-covered services.  
I understand that I am responsible for payment of any applicable co-payments, co-insurance, deductibles or non-covered services at the time of service. In signing this form I acknowledge that I am responsible for the bill not paid by the insurance carrier.  
I understand that my health information will be used for treatment, payment and healthcare operations, (see the Notice of Privacy Practice).  
By providing your contact information, you agree to receive information, such as appointment reminders, patient surveys and other information relating to your therapy services via the communication channels you provided above.

\_\_\_\_\_  
Patient/Legal Guardian Signature Date

Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
INITIAL I acknowledge that I have been given the Notice of Privacy Practices and that if I have any questions I can contact the Compliance Department.



**MEDICAL HISTORY AND PREVIOUS TREATMENT 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
- 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?

- |     |    |                           |     |    |   |
|-----|----|---------------------------|-----|----|---|
| 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 |

**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? \_\_\_\_\_

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:** \_\_\_\_\_

**Thank you for completing this questionnaire. It will allow us to better serve your needs.**

Therapist signature: \_\_\_\_\_ Date: \_\_\_\_\_