REHABILITATION WORKS CLIENT INFORMATION /NOTICE OF PRIVACY PRACTICE FORM

PATIENT INFORMATION:

Name: _____ Birth date: _____ Sex: M_____ F_____

Address: _____ City/State: _____ Zip: _____

SSN #: _____-_____ -_____ Home Ph. #: _____ Work #: _____

Cell Phone #:_____ E-mail : _____

Employer: _____Employer Address: _____

If patient under 18, name of legal guardian: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you choose Rehabilitation Works? [ ] Physician [ ] Friend/Family (name optional): _____

[ ] Yellow Pages [ ] Insurance participation [ ] Geographic location [ ] Other: _____

PATIENT CARE INFORMATION

Onset of pain/injury/surgery date: (required) _____ Injury Area/Diagnosis: _____

Referring Physician: _____ Primary Care Physician: _____

- Have you had previous therapy this year? YES NO (If YES, Circle: Physical/Occupational/Speech)
- Is this related to an auto accident? YES NO
- Is this a workman's compensation claim? YES NO
- Is this covered under a liability claim? YES NO

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

WORKMAN'S COMPENSATION/AUTO CARRIER: _____

Adjustor/Contact Person: _____ Phone: _____

NOTICE OF PRIVACY PRACTICE

By signing below, I acknowledge that a copy of Notice of Privacy Practices Policy has been made available.

_____ _____

Signature of patient or personal representative Print patient name

_____ _____

Relationship to patient if signed by a personal representative Date signed

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Office use only: Our Practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our Practice must document its good faith efforts to obtain such acknowledgement and record the reason that the acknowledgement was not obtained.

Refused to sign _____ Physically unable to sign _____ Other _____ Employee Signature: _____ Date: _____

Office use: (revised 1/10) F:\Rach\Rehabilitation Works Client Information Form2010

Client #: _____ Diagnosis: _____ Therapist #: _____ Date:_____

REHABILITATION WORKS PATIENT MEDICAL HISTORY

Please identify any conditions that you have experienced or with which you have been diagnosed:

Current	*Past*	ORTHOPEDIC
___	___	Osteoporosis
___	___	Arthritis/degenerative joint disease
___	___	Rheumatoid arthritis
___	___	Scoliosis
___	___	Intervertebral disc disorder
___	___	Spinal stenosis
___	___	Radiating symptoms to arms or legs
___	___	Spinal compression fractures
___	___	Other fractures _____
___	___	Joint replacement _____
___	___	Amputation
___	___	Sprain/strain
___	___	Rotator cuff disorder
___	___	Ruptured tendon
___	___	Osteomyelitis
___	___	Carpal tunnel
___	___	Other pain/problems with:
___	___	Neck/spine
___	___	Shoulders
___	___	Elbows
___	___	Wrists
___	___	Hands/fingers
___	___	Hips
___	___	Knees
___	___	Ankles/feet
___	___	Pelvic pain

Current	*Past*	NEUROLOGIC
___	___	Parkinson's
___	___	ALS
___	___	Muscular dystrophy
___	___	Multiple sclerosis
___	___	Myasthenia gravis
___	___	Reflex sympathetic dystrophy
___	___	Alzheimer's
___	___	Seizures/epilepsy
___	___	Anoxia
___	___	Vertigo/dizziness
___	___	Ménière's disease
___	___	Numbness or tingling
___	___	Nerve injury
___	___	Shingles
___	___	Headaches/migraines
___	___	Polio/post-polio syndrome

Current	*Past*	CARDIOPULMONARY
___	___	High/low blood pressure (circle one)
___	___	Chest pain with exertion
___	___	Shortness of breath with exertion
___	___	Congestive heart failure
___	___	Heart attack
___	___	Heart surgery
___	___	Cardiac dysrhythmia (irregular heartbeat)
___	___	Aneurysm (circle: aortic / brain)
___	___	Stroke / intracranial bleed
___	___	Blood clot (DVT)
___	___	Pulmonary embolism
___	___	Emphysema
___	___	Asthma
___	___	Respiratory distress
___	___	Lymphedema
___	___	Swelling in hands or feet/legs
___	___	Raynaud's Syndrome

Current	*Past*	MISCELLANEOUS
___	___	Abnormal weight loss/gain (circle)
___	___	Anemia
___	___	Anxiety
___	___	Bronchitis / pneumonia
___	___	Burns
___	___	Cancer _____
___	___	Chronic Fatigue Syndrome
___	___	Diabetes
___	___	Dehydration
___	___	Depression
___	___	Dysphagia (difficulty swallowing)
___	___	Fainting spells
___	___	Falls
___	___	Fibromyalgia
___	___	Head injury / concussion
___	___	Hearing loss
___	___	Incontinence
___	___	Kidney failure
___	___	Low vision/blindness
___	___	Memory loss
___	___	Metal implants
___	___	Open wounds _____
___	___	Thyroid disorder
___	___	Voice or speech disturbance

Patient Name _____ *Date* _____

Chief reason for seeking
therapy:_____

Previous physical, occupational or speech therapy for this condition? ___ NO ___ YES
If yes, when and where? _____

Previous physical, occupational or speech therapy for a different condition? ___ NO ___ YES
If yes, when and why?

_____
_____

Do you have a pacemaker? ___ NO ___ YES

Surgeries or hospitalizations? _____
_____
_____
_____
_____

Medications: _____
_____
_____
_____
_____

Allergies to medications: _____

to latex: _____ to ointments, creams, tape, etc. _____

Females: Is there a possibility that you could be pregnant? ___ NO ___ YES

Next appointment with referring doctor: _____

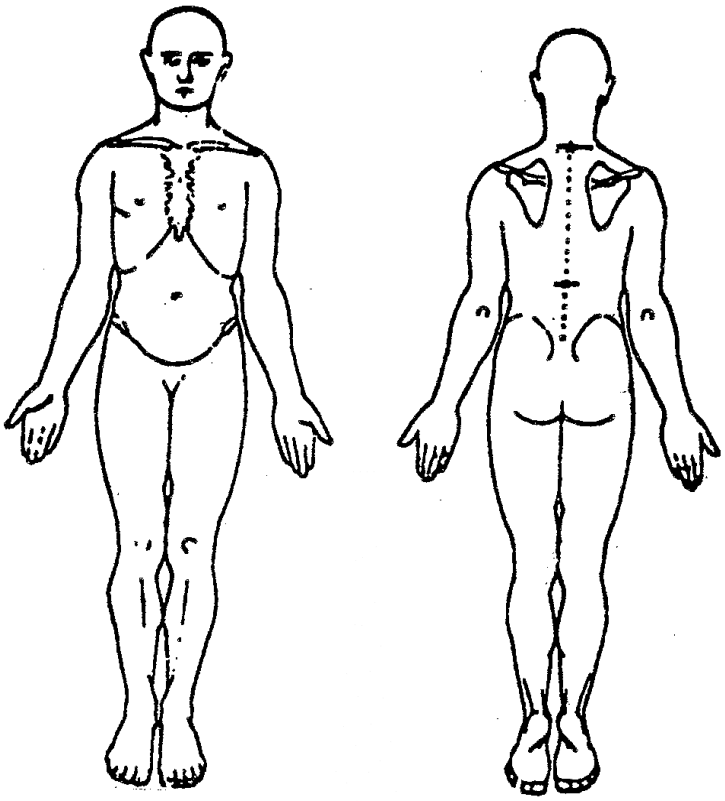
Please identify any activity with which you are having difficulty or unable to do:

___ Dressing self
___ Bathing self
___ Preparing meals
___ Caring for children/family members
___ Verbally expressing self
___ Concentrating on tasks
___ Short-term memory
___ Long-term memory
___ Sleeping
___ Sexual intimacy
___ Controlling/holding urine
___ Bending to pick up or reach item on floor
___ Getting in/out of bed
___ Getting in/out of chair or sofa
___ Getting in/out of the car
___ Driving a car
___ Sitting less than 15 minutes
___ Sitting longer than 15 minutes
___ Standing less than 15 minutes
___ Standing longer than 15 minutes
___ Walking less than 1 city block
___ Walking more than 1 city block
___ Walking outdoors on uneven terrain
___ Going up or down stairs
___ Gardening
___ Playing/participating in a sports activity
___ Job duties
___ Any other activity you normally participate in:
_____

Patient Name _____ *Date* _____

PAIN ASSESSMENT

Location of pain:



Rating of pain:

Best level in past 3 days:

0 1 2 3 4 5 6 7 8 9 10

(no pain) (excruciating pain)

Worst level in past 3 days:

0 1 2 3 4 5 6 7 8 9 10

(no pain) (excruciating pain)

Description of pain (check as many as apply):

___ burning	___ aching	___ worst first thing in the morning
___ sharp	___ dull	___ better first thing in the morning
___ piercing	___ throbbing	___ worse with activity
___ stinging	___ numbing	___ better with activity
___ tingling	___ deep	___ awakens from sleep

Other _____

What makes it worse?_____

What makes it better? _____

Are you taking medication for pain? ___ NO ___ YES – if so, what kind? _____

How much/how often? _____ Does it help? _____

Patient Name _____ *Date* _____