Appt Date / Time / PT _____

Last Name _____ First Name _____ (MI) ____

DOB _____ Gender M F Phone _____ Phone _____

Home Address _____

Employer Name _____

Permission to leave Phone voice messages? Y or N * contact number

Email Address: _____
(This can be used for contact with the office, appointment verification, treatment updates, etc.)

Emergency Contact _____ Phone # _____

Referring Physician _____

Body Part _____ DOS _____ DOI _____

Accident Type and Details _____

☐ Fed Black Lung ☐ End Stage Renal Disease ☐ Group Health ☐ Auto ☐ 3rd Party Liability ☐ Veterans Admin ☐ W/C ☐ Home Health

Ins. Company _____ Type of Plan _____ 2ndary Ins Y or N

Policy # _____ Group # _____ Member Services _____

Policy Holder _____ Relationship _____DOB_____
MEDICARE Have you had Home Health in past 60 Days?_____
Employer Name _____

Home Address _____Phone _____

Consent for Care

I do hereby agree and give my consent for Advanced Rehabilitation to furnish medical care and treatment considered necessary and proper in the evaluation and treatment of my physical conditions.

Patient/Guardian Signature _____ **Date** _____

Assignment of Benefits/Release of Information

I certify that all information on this form is correct. I hereby assign all medical benefits to which I am entitled, to include major medical, Medicare, Medicaid, private insurance and third party payors to Advanced Rehabilitation. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Advanced Rehabilitation to release all information necessary, including medical records to secure payment.

Patient/Guardian Signature _____ **Date** _____

Facility Representative _____ **Date** _____

PATIENT MEDICAL HISTORY

Name: _____ **Account Number** _____
Referring Physician: _____ **Occupation:** _____
Family Physician: _____ **Last Date Worked:** _____
Attorney Involved? YES NO **Date Returned to Work:** _____
Prior Surgery for this condition? YES NO Type of Surgery: _____
MEDICARE PATIENTS Height:_____ **Weight:**_____

Are You Currently Taking ANY Prescription or Non-Prescription Medications? YES NO

Anti-inflammatories	____	**List Medications** ☐ **Separate list attached**
Muscle Relaxers	____	_____
Pain Medication	____	_____
Antibiotics	____	_____

Have you had any of the following Medical or Rehabilitative Services for THIS Injury/Episode?

	YES	NO		YES	NO
Chiropractor	___	___	CT Scan	___	___
EMG/NCV	___	___	General Practitioner	___	___
Massage Therapy	___	___	MRI	___	___
Myelogram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room Care	___	___	X-Rays	___	___

Other:_____

Do you NOW HAVE or HAVE YOU EVER HAD ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	___	___	Severe or Frequent Headaches	___	___
Shortness of Breath/Chest Pain	___	___	Vision or Hearing Difficulties	___	___
Coronary Heart Disease or Angina	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker?	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Ringing in your Ears	___	___
Heart Attack or Surgery	___	___	Weakness	___	___
Stroke/TIA	___	___	Weight Loss/Energy Loss	___	___
Blood Clot/Emboli	___	___	Hernia	___	___
Epilepsy/Seizures	___	___	Tuberculosis	___	___
Thyroid Trouble/Goiter	___	___	Allergies	___	___
Anemia	___	___	Any Pins or Metal Implants	___	___
Infectious Diseases	___	___	Joint Replacement	___	___
Diabetes	___	___	Neck Injury/Surgery	___	___
Cancer or Chemotherapy/Radiation	___	___	Shoulder Injury/Surgery	___	___
Arthritis/Swollen Joints	___	___	Elbow/Hand Injury/Surgery	___	___
Osteoporosis	___	___	Back Injury/Surgery	___	___
Gout	___	___	Knee Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Emotional/Psychological Problems	___	___	Are You Pregnant?	___	___
Bowel or Bladder Problems	___	___	Do You Smoke?	___	___

Please list any other information that would assist us in your care: _____
_____

Are you aware of what your diagnosis is? YES NO
Based upon your awareness, what are your expectations and/or goals of rehabilitation?
_____

It is the policy of Advanced Rehabilitation for all patients to have an opportunity during the first visit, to discuss the evaluation findings, the proposed Plan of Care by the therapist and have any and all questions answered satisfactorily prior to commencing therapy.

Patient/Guardian Signature: _____ **Date:** _____

Advanced Rehabilitation