Real Health Rehab

Date______________________

PERSONAL INFORMATION

Name____ Date of Birth______________________

Street Address_____________________________________ Age_________ Gender: ☐ Male ☐ Female

City____ Social Security #______________________

State___________ Zip____________________

CONTACT INFORMATION

Cell Phone ___________________________________ Home Phone ___________________________
(Parent/Guardian's # if patient under 18 years old)

Email _______________________________________ Work Phone ____________________________
(automatic 24hr advance appointment reminders)

Parent/Guardian Name____________________________________ Phone_________________________
(if patient under 18 years old)

Emergency Contact____ Phone_________________________

Contact Relationship: ☐ Spouse ☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Guardian ☐ Other

MEDICAL HISTORY

Referring Physician ____ Location______________________

Primary Care Physician _______________________________________ Location______________________

Date of next Physician visit ___________________________

Please check the appropriate response	Yes	No
Is your current condition auto accident related?		
Is your current condition work related?		
Have you received or are you receiving physical, occupational, massage, chiropractic or pain management from any other facility or provider at this time? If yes, please explain		

Whom may we thank specifically for this referral?

HEALTH QUESTIONNAIRE

Patient Name ____ Date ______________________

1) Date of Injury ________________________Date of Surgery (if applicable) __________________________

2) Please describe your symptoms (including how & when they started, aggravating & relieving factors, etc.)

____

____

____

3) How often do you experience your symptoms?
☐ Constantly (100% of the day) ☐ Frequently (25-75% of the day) ☐ Intermittently (0-25% of the day)

4) What describes the nature of your symptoms?
☐ Sharp ☐ Dull Ache ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling

5) How are your symptoms changing? ☐ Getting Better ☐ Not Changing ☐ Getting Worse

6) During the past 4 weeks:
Indicate the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10
None Worst Imaginable

7) Who have you seen for your symptoms?
☐ Medical Doctor ☐ Chiropractor ☐ No One ☐ Other ____________________________

What treatment did you receive?________________________________ When?____________________

What tests have you had? X-Rays _______________ (date) MRI _______________ (date) Other _______________ (date)

8) Have you had similar symptoms in the past? ☐ Yes ☐ No
If yes, please explain____

9) In general, your overall health right now is? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

10) Do you exercise regularly? YES / NO

11) How would you consider your occupation? ☐ active ☐ sedentary

12) How would you describe your dietary habits? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

13) Do you smoke? YES / NO If yes, how many packs a day?________ For how many years?_________

14) How much sleep do you get per night? ________________

HEALTH QUESTIONNAIRE continued…

Please check/circle if you have ever (in your life) had, or do you presently have any of the following:

- ☐ Osteoporosis
- ☐ Bone Joint Problem
- ☐ Arthritis/Rheumatism
- ☐ Allergies
- ☐ Back Trouble
- ☐ Breathing Problems (any kind)
- ☐ Broken Bones/Dislocation/Sprains
- ☐ Cancer or Tumor
- ☐ Skin Disease or Sores that won't heal
- ☐ Dizziness/Fainting
- ☐ Epilepsy/Seizure Disorder
- ☐ Fibromyalgia Syndrome
- ☐ Headaches/Migraines
- ☐ Head/Spinal Injury
- ☐ Heart Disease/Chest Pain
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pacemaker/Defibrillator
- ☐ Pregnancy (current)
- ☐ Hernia/Rupture
- ☐ Diabetes - Type I / Type II
- ☐ Stroke/Neurological history
- ☐ Swelling of Feet or Joints
- ☐ Urinary Incontinence
- ☐ Surgeries (list below)
- ☐ Other (explain)____

____

____

____

Surgery/ Procedure	Date

MEDICATIONS

Are you allergic to any medications? YES / NO If YES, what?____

If you are currently taking any medications please list below

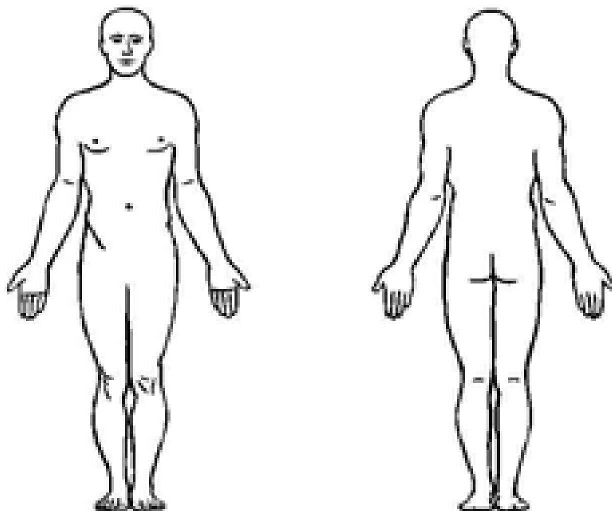
1		5	
2		6	
3		7	
4		8	

I certify that I have reviewed and understand the above information supplied by me, and that it is true and correct to the best of my knowledge. I hereby consent to such treatment, procedures and patient care which, in the judgment of my physical therapist and/or physician, may be considered necessary or advisable while a patient at Real Health Rehab.

Patient Signature ____ Date_______________________

HEALTH QUESTIONNAIRE continued…

MARK THE AREAS OF YOUR SYMPTOMS
ON THE FIGURE TO THE RIGHT -->



On a scale from 1 to 10:

How bad are your symptoms now?

1 2 3 4 5 6 7 8 9 10

How bad have they been in the past?

1 2 3 4 5 6 7 8 9 10

Primary Insurance

Insurance:__________________________

ID#________________________________

Group#_____________________________

Card Holder's Name:______________________________

Relationship to patient: ____Self _____Spouse ______Child

Secondary Insurance

Insurance:__________________________

ID#________________________________

Group#_____________________________

Card Holder's Name:______________________________

Relationship to patient: ____Self _____Spouse ______Child

Patient or Parent/Guardian Signature____
Date_________________

AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION I, the below named patient, hereby authorize Real Health Rehab to release to any third party (such as an insurance company or governmental agency, example: Anthem BC/BS, UHC, or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PRIVACY PRACTICES I, the below named patient, understand that I am entitled to certain privacy rights regarding protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I also understand and have been given the opportunity to receive a copy of the entire Notice of Privacy Practices prior to signing this consent and understand that I may revoke this authorization in writing, except to the extent that action has already been taken.

CONSENT TO DISCLOSE PATIENT INFORMATION / HIPPA I, the below named patient, parent or guardian understand this center's Notice of Privacy Practices and give permission for my (my child's, child under my guardianship) protected health information to be disclosed for the purposes of communicating results, findings, care decisions, legal matters and appointments/scheduling to my doctors involved in my care as well as my lawyer representing me, as well as the family members listed below.

CONSENT TO LEAVE MESSAGES ON YOUR ANSWERING MACHINE (please initial one answer below):

YES Please leave me messages ________ **NO** Please do not leave me messages ________

FAMILY MEMBERS AND/OR LEGAL GUARDIAN (Please list family members and legal guardians below that may have access to information about you or your child from Real Health Rehab)

1

2

3

Patient Name (please print)____

Patient or Parent/Guardian Signature ____________________________________ Date_________________

ATTENDANCE POLICY

At Real Health Rehab we strive to give all patients the personal attention they deserve. The following guidelines have been established in order to achieve this goal. Please sign your agreement to our attendance policy below.

1) I understand that if I am late for a scheduled appointment, I may not be able to be seen that day.
2) If I need to cancel an appointment, I will give **24 hours** in advance to notify the office. I will leave a voicemail if my call is not during normal business hours. I understand there is a $75.00 fee for a cancellation without proper notice. I understand that this will be billed to me and is not covered by insurance. (Last minute emergencies are excused of course)
3) I understand there is a $75.00 fee for missing a scheduled appointment without any notification. I understand that this will be billed to me and is not covered by insurance. (Last minute emergencies are excused of course)
4) I understand that if I miss 2 or more consecutive appointments without notice, I may be discharged from physical therapy.

Patient or Parent/Guardian Signature ____________________________________ Date_________________