

Name:	Preferred:
Address, City, State, Zip:	
DOB:	Social security #:
Email Address:	

Home Phone:	Appointment Reminder Method
Cell Phone:	<input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone
Work Phone:	<input type="checkbox"/> Text Message Reminder <input type="checkbox"/> Voice Call Reminder

Please keep in mind that communication via email over the Internet is not a secure form of communication. By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Partner's name:
2nd contact name/address:	
2nd contact phone:	Relation:
General Physician:	Referred by:

Have you had Physical Therapy treatment since January of this year? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of visits:
Have you had Chiropractic treatment since January of this year? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of visits:
Have you had Home Healthcare in the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, Home Healthcare Provider:	

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information.	
Financial Responsibility: <input type="checkbox"/> Self <input type="checkbox"/> Other, please list:	
Primary Insurance:	Secondary Insurance:
Policy #	Policy #
Group #	Group #
Insured Name:	Insured Name:
Insured DOB:	Insured DOB:

Consent to Treat/Assignment of Benefits/Acknowledgements	
<p>I hereby authorize and consent to treatment/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 provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.</p> <p>I assign payment for these services directly to ProRehab. I authorize the filing of claims to my insurance plan and authorize ProRehab to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.</p> <p>In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believed were covered services, resulting in my responsibility for paying for these services.</p> <p>I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.</p>	
_____ Signature of Patient/Guardian	_____ Date
_____ Print name and relationship to the patient	

PATIENT HEALTH QUESTIONNAIRE

Patient Name:

Name You Go By:

What are your pronouns? He/Him She/Her They/Them Other:

Do you think of yourself as: Male Female Transgender

Neither exclusively male nor female Additional gender category, please specify: _____ Decline to Answer

What sex was originally listed on your birth certificate? Male Female Decline to Answer

For billing purposes, it is helpful to know gender assigned at birth. There can be confusion when a patient legally changes their birth certificate to the gender they align with, but insurance companies' data is lagging behind.

Occupation:

Height:

Weight:

Are you? Right-handed Left-handed

Leisure Activities/Hobbies:

Where do you live? Private Home Apartment/Rented Room Assisted Living/Group Home
 Hospice Other:

With whom do you live? Alone Spouse Only Spouse and Others Child Other:

Does your home have? Stairs, No Railing Stairs, Railing Ramps Uneven Terrain

Please explain:

How many times have you fallen in the past 12 months?

Did it result in an injury? Yes No

During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? Yes No

General Health Status: Please rate your health. Excellent Good Fair Poor

Please list any known allergies (including medications, latex, etc.) below.

Current Condition

When did this problem(s) first begin/date of onset?

If chronic, when did you seek medical treatment?

Is your current condition related to recent surgery? Yes No If yes, specify date of surgery:

Describe the problem(s).

Explain how problem(s) occurred.

Have you ever had this problem before? Yes No If yes, how many times?

Are your symptoms worse in the: Morning Afternoon Evening Night Same All Day

How are you taking care of the problem(s) now?

My pain/problem is slowing getting: Worse Better Staying the Same

My symptoms bother me: Constantly (100%) Most of the Time (75%)
 Occasionally (50%) Once in a While (25%)

Do you have any numbness, tingling, or burning? Yes No If yes, please check one: Constantly Intermittently

What functions could you perform before, that you now are unable to do?

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 for this problem? If so, please list the dates and results.

Are you aware of any physical reason why you should not receive treatment? Yes No

If yes, please tell us what it is:

What are your goals for therapy?

Surgery / Hospitalization, please include date and reason.	

Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.				
Name	Dosage	Frequency	Please Indicate Route	
			Oral	Patch Topical Other
			Oral	Patch Topical Other
			Oral	Patch Topical Other
			Oral	Patch Topical Other
			Oral	Patch Topical Other

Social History / Wellness	
Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No
How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? <input type="checkbox"/> At least 3 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Seldom or Never	

Are you currently experiencing any of the following?			
Nausea or Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pains (Angina)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Productive/Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Wakes Me at Night	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Fever, Chills, Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Loss/Ringing in Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unusual Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue or Myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Pain or Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained Weight Changes	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you been diagnosed with any of the following?			
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis, If Yes, Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Auto Immune Disease If yes, Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Cord Stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel or Bladder Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer, If yes, Site:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peripheral Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No

I will advise the therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.

Signature: _____ Date: _____

Clinician Signature: _____ Date _____