



Patient Data Sheet

| PATIENT INFORMATION | | | |
|--|-------|--|---|
| Patient Name: _____ | | Date of Birth: _____ | |
| Last | First | MI | |
| Social Security No.: _____ | | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W |
| Address: _____ | | City: _____ | State: _____ Zip: _____ |
| Home Phone: _____ | | Cell Phone: _____ | Work Phone: _____ |
| OK to leave detailed message? <input type="checkbox"/> Yes <input type="checkbox"/> No | | OK to leave detailed message? <input type="checkbox"/> Yes <input type="checkbox"/> No | OK to leave detailed message? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Email Address: _____ | | Preferred method of contact: _____ | |
| Notify in case of Emergency: _____ | | Phone number: _____ | |
| Race: <input type="checkbox"/> Am Indian <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pac Islands <input type="checkbox"/> White <input type="checkbox"/> Other | | | |
| Ethnic Background: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino | | | |
| Smoking Status: <input type="checkbox"/> Every Day Smoker <input type="checkbox"/> Some Day Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoker <input type="checkbox"/> Unknown | | | |

| INSURANCE SUBSCRIBER INFORMATION | |
|---|---|
| Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other | |
| Name: _____ | Birthdate: _____ |
| Address: _____ | |
| Home Phone: _____ | Work Phone: _____ Social Security No. _____ |
| Employer: _____ Employer address: _____ | |
| Sex: <input type="checkbox"/> M <input type="checkbox"/> F | Occupation: _____ |

| ACCIDENT INFORMATION | |
|---|--|
| Did you have Surgery: <input type="checkbox"/> Yes <input type="checkbox"/> No Surgery Date: _____ Accident/Injury type: <input type="checkbox"/> Workers Comp* <input type="checkbox"/> Auto <input type="checkbox"/> Other: | |
| Accident / Injury Date / Date Doctor was seen for this problem: ____/____/____ Briefly describe accident: _____ | |
| *If Worker's Comp - Employer: _____ State: _____ | |

| INSURANCE POLICY INFORMATION | |
|--|--|
| <i>This information will be used for billing purposes; please present your insurance card and a photo ID to the front desk receptionist.</i> | |
| Primary Insurance Name: _____ | Phone: _____ |
| Policy / Claim #: _____ | Group #: _____ |
| Insured Name: _____ | Authorization / Pre-Certification: _____ |
| Secondary Insurance Name: _____ | Phone: _____ |
| Policy / Claim #: _____ | Group #: _____ |
| Insured Name: _____ | Authorization / Pre-Certification: _____ |
| Have you received physical therapy, occupational therapy, or chiropractic services this year? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| I have reviewed the above information and verify that it is correct. | |
| Patient / Guardian signature: _____ | Date: _____ |

| ***** OFFICE USE ONLY ***** | |
|---------------------------------------|---|
| Referring Physician: _____ | Phone #: _____ UPIN #: _____ |
| Admit Date: ____/____/____ | RX Date: ____/____/____ Therapist Name: _____ |
| Body Part / PT / OT / DURATION: _____ | |
| Service Class: _____ | FSC Code: _____ Intake Completed By: _____ |



How Did You Hear About Crest?

Please check all that apply:

- Returning Patient
If you are a returning patient, are you returning due to an EMAIL sent to you? YES NO
- Doctor Referral: _____
Referring Doctor's Name
- Insurance Company Referral
- Family Member or Friend
- Atlantic Club Gym Member
- Social Media: Facebook Instagram Other: _____
- Internet Search: Google Yelp Other: _____
What key word(s) did you search? _____
- Advertisement: Newspaper Flyer/Billboard Radio Other: _____
- Crest Employee: *Name of Crest Employee* _____
- Other: _____
Please Tell Us How You Heard of Us

Name Printed

Referring Doctor's Name

Email

Date

OFFICE USE ONLY

Intake Reviewed by: _____ Date: _____



Financial Policy Statement

CREST PHYSICAL THERAPY calls your insurance company in advance of your treatment to verify what they will and/or will not cover, and what your responsibility may be. This is an **“estimation” of your benefits and not a guarantee** they will pay that way. Your total share may be more than the payments (i.e., co-pays) you have been making to the facility (CREST).

Your insurance company may send Payments and Explanations of Benefits directly to you. The explanation of benefits itemizes what was covered/paid to both the patient and to CREST PHYSICAL THERAPY. CREST PHYSICAL THERAPY will send a letter/bill asking for any further amounts due for that billing period, if any. You may also receive an automated reminder call for any balance due at the end of your treatment. If at any time you feel your insurance company processed your claim incorrectly, please contact them directly.

If at any time during your therapy, your insurance changes, please inform facility front desk as soon as possible.

Benefit Assignment/Release of Information

I request that payment of authorized benefits be made either to me or on my behalf to Crest Physical Therapy for services furnished by Crest Physical Therapy. If these benefits are not assigned to Crest Physical Therapy, I agree to forward the practice all health insurance and/or third-party payments I receive for services immediately upon receipt. I will promptly pay Crest Physical Therapy for all amounts **not paid by my insurer(s) and for which I am responsible according to my insurance plan’s participation criteria. This includes** but is not limited to co-insurance, deductibles, and non-covered items. I authorize release to the indicated insurance carrier any medical information about me needed to determine these payments for related services.

By signing below, you agree to forward the payment and Explanation of Benefits to CREST PHYSICAL THERAPY. Without the Explanation of Benefits, the payments may not be applied correctly, which could result in you being sent a bill for your visits.

Please be advised that you must make a co-insurance/copay/deductible payment for each visit with Crest Physical Therapy. Your co-insurance/copay/deductible is \$_____, as per your insurance company. By signing below, you agree to make your co-insurance/copay/deductible payment on each visit. We accept Visa, MasterCard, American Express, checks, money orders, and cash.

No Show Policy and Fee

It is the policy of this facility to charge a **“no show” fee of \$25.00 to patients who miss or cancel an appointment with less than 24 hours’ notice.** This fee may be waived at the discretion of the CREST Administrative Director based on individual circumstances of the patient (e.g., family illness or accident). Should you cancel or no show three times over the course of one month **with less than 24 hours’ notice** we will no longer be able to schedule appointments in advance for you, however, you will be able to call on the day you would like to come in to schedule during an open time.

Thank you for choosing CREST PHYSICAL THERAPY.

By signing below you are stating that you have read and understand this form:

SIGNATURE

DATE

PRINT NAME

OFFICE USE ONLY

Intake Reviewed by: _____ Date: _____



Notice of Privacy Practices

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call **this information "protected health information", or "PHI" for short and it includes information that can be used to identify you that we've created or received** about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in [insert location where notice will be posted, e.g., main reception area]. You can also request a copy of this notice from the contact person listed in Section IV below at any time.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization.

We may use and disclose your PHI without your authorization for the following reasons:

1. For treatment. We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, if **you're being treated for a knee injury, we may disclose** your PHI to an x-ray technician in order to coordinate your care.
2. To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you.
3. For health care operations. We may disclose your PHI in order to operate this practice. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others **in order to make sure we're complying with the laws that affect us.**
4. When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement

personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; or when ordered in a judicial or administrative proceeding.

5. For public health activities. For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an **individual's death.**
 6. For health oversight activities. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
 7. For purposes of organ donation. We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.
 8. For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.
 9. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
 10. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
 11. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.
 12. Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.
- B. Use and Disclosure Where You Have the Opportunity to Object:
1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.
 2. All Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any **future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).**
 3. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure.



Notice of Privacy Practices

However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient at a nursing station that might be **overheard by personnel not involved in the patient's care** would be permitted.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. **The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

C. **The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make **the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it.** We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge you \$1 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. **The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directory. **The list also won't include** uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or in compliance with National Instant Criminal Background Check System as of 1/7/14.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a

shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you \$10 for each additional request.

E. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We will respond within 30 days of receiving your request in writing. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. **If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI.** If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: **Physicians' Practice Enhancement, LLC, Attn: Human Resources; 66 West Gilbert Street, Suite 100; Red Bank, New Jersey 07701-4918; (732) 212-0060; e-mail: info@ppenet.com.**

VII. EFFECTIVE DATE OF THIS NOTICE.

This notice went into effect on January 1, 2015.



Senior Home Safety Checklist

| Area | Observation | Remedy |
|-------------------------|---|---|
| Floors | When you walk through a room, do you have to walk around furniture? | Move the furniture so the path is clear. |
| | Throw rugs on the floor? | Remove the rugs or use double-sided tape or a non-slip backing so the rugs won't slip |
| | Are papers, magazines, books, shoes, boxes, blankets, towels, or other objects on the floor? | Always keep objects off the floor |
| | Do you have to walk over or around cords or wires (like cords from lamps, extension cords, or telephone cords)? | Coil or tape cords and wires next to the wall so you can't trip over them. Have an electrician put in another outlet. |
| Stairs and Steps | Are papers, shoes, books, or other objects on the stairs? | Keep objects off the stairs. |
| | Are some steps broken or uneven? | Fix loose or uneven steps |
| | Are you missing a light over the stairway? | Have an electrician put in an overhead light at the top and bottom of the stairs. |
| | Do you have only one light switch for your stairs | Have an electrician put in a light switch at the top and bottom of the stairs. |
| | Is there a sturdy handrail on only one side of the stairs? | Make sure handrails are on both sides of the stairs and are as long as the stairs |
| | Is the carpet on the steps loose or torn? | Make sure the carpet is firmly attached to every step or remove the carpet and attach non-slip rubber treads on the stairs. |
| Kitchens | Are the things you use often on high shelves | Keep things you use often on the lower shelves (about waist high). |
| | Is your step stool unsteady? | Use a steady step stool with a bar to hold on to |
| Bedrooms | Is the light near the bed hard to reach? | Place a lamp close to the bed |
| | Is the path from your bed to the bathroom dark? | Use a night-light |
| | Is the tub or shower floor slippery? | Put a non-slip rubber mat or self-stick strips on the floor of the tub or shower |
| | Do you have some support when you get in and out of the tub or up from the toilet? | Install grab bar inside the tub and next to the toilet. |

Other Things You Can Do To Prevent Fall

- Exercise regularly. Exercise makes you stronger and improves your balance and coordination.
- Have your doctor or pharmacist look at all the medicines you take, even over-the-counter medicines. Some medicines can make you sleepy or dizzy.
- Have your vision checked at least once a year by an eye doctor. Poor vision can increase your risk of falling.
- Get up slowly after you sit or lie down.
- Wear sturdy shoes with thin, non-slip soles. Avoid slippers and running shoes with thick soles.

- Improve the lighting in your home. Use brighter light bulbs (at least 60 watts). Use lamp shades or frosted bulbs to reduce glare.
- Use reflecting tape at the top and bottom of the stairs so you can see them better.
- Paint doorsills a different color to prevent tripping.

Other Safety Tips

- Keep emergency numbers in large print near each phone.
- Put a phone near the floor in case you fall and can't get up.
- Consider wearing an alarm device that will bring help in case you fall and can't get up.



Patient Agreements

Please read the following statements and indicate your acknowledgement and/or authorization for each below with your initials:

_____ I hereby authorize the staff of *CREST PHYSICAL THERAPY* to provide and perform any medical care and treatment deemed necessary or beneficial for my health and wellbeing and appropriate in diagnosing or treating my physical and/or mental condition.

_____ *CREST PHYSICAL THERAPY* calls your insurance company in advance of your treatment to verify what they will and/or will **not cover, and what your responsibility may be. Please realize that the information they give us is just an "estimation" of your benefits and not a guarantee they will pay that way.** All payments you make at the facility are only intended to go towards your total patient share and may not be your final responsibility. If at any time during your therapy, your insurance changes, please inform facility front desk as soon as possible.

_____ *CREST PHYSICAL THERAPY* is an in-network provider for Medicare, but may not be an in-network provider with your secondary insurance. Your secondary insurance company may be sending all Payments and Explanations of Benefits directly to you. The explanation of benefits itemizes what was covered/paid to both the patient and to *CREST PHYSICAL THERAPY*. *CREST PHYSICAL THERAPY* will send a letter/bill asking for any further amounts due for that billing period, if any. You may also receive an automated reminder call for any balance due at the end of your treatment. If at any time you feel your insurance company processed your claim incorrectly, please contact them directly. Bills unpaid for more than 90 days may be turned over to a collection agency, Wakefield & Associates.

_____ *CREST PHYSICAL THERAPY* collects information including your home address, home and mobile phone numbers, and email to deliver patient statements, alerts, newsletters, surveys, and other communications. You can opt out of marketing communications at any time. We will never sell, rent, or give away our patient information list for 3rd party marketing.

PATIENT PERMISSION TO SHARE PROTECTED HEALTH INFORMATION

_____ I hereby authorize the staff of *CREST PHYSICAL THERAPY* to **use or disclose my health information (referred to as "Protected Health Information")** to any healthcare provider and/or employee of Crest Physical Therapy. The Protected Health Information (PHI) I am authorizing for use of disclosure is the standard release of information (includes typed diction and therapy notes) and specific information from my chart which includes: _____.

_____ I hereby authorize and request *CREST PHYSICAL THERAPY* to disclose my PHI to the person(s) or institution(s) listed below. I understand that this authorization will expire 180 days from signing, unless an earlier date is indicated: _____.

| <u>Authorized Name(s)</u> | <u>Relationship to patient</u> | <u>Authorized Mailing Address</u> |
|---------------------------|--------------------------------|-----------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

_____ I understand that *CREST PHYSICAL THERAPY* has the right to bill me \$1.00 per page for each copy of my PHI.



Patient Agreements

FINANCIAL POLICY STATEMENT

_____ I understand my responsibility for the payment of my account.

_____ I understand and agree that if I fail to make any of the payments for which I am responsible, in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I have received and reviewed the Notice of Privacy Practices.

RECEIPT OF SENIOR HOME SAFETY CHECKLIST

_____ I have been offered the Senior Home Safety Checklist.

REVOKING RIGHTS FOR PATIENT AGREEMENT

_____ I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if *CREST PHYSICAL THERAPY* has taken action in reliance upon this Authorization or, if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy. I understand that I may revoke this Authorization by sending a written request to:

Crest Physical Therapy
66 West Gilbert Street
Red Bank, NJ 07701

This consent shall remain in effect until revoked in writing.

By signing this Authorization, I acknowledge that I have read and understand this Authorization.

Signature (Patient)

Date

Signature (Authorized Representative)

Date

Name Printed

Relationship of Authorized Representative to Patient

Patient's Telephone #

Patient's Date of Birth

OFFICE USE ONLY

Intake Reviewed by: _____ Date: _____



Patient Medical History

Patient Name _____ ID #: _____ Date: _____

Referring Physician: _____ Family Physician: _____

Regarding this injury: First Doctor Visit: ___/___/___ Last day Worked: ___/___/___ Date Returned to Work: ___/___/___

Have you had surgery for this injury? YES NO Took place in: Hospital Surgery Center Is an attorney involved in this case? YES NO

Number of surgeries: _____ Type of Surgery: _____

Have you had any of the following medical or rehabilitative services for this injury/episode?

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

Have you had two (2) or more falls, or any fall resulting in injury, in the past year? YES NO

If yes, please explain: _____

Do you now have or have you ever had ANY of the following?

| | YES | NO | | YES | NO |
|----------------------------------|-------|-------|--|-------|-------|
| Allergies | _____ | _____ | Heart Attack or Surgery | _____ | _____ |
| Vision or Hearing Difficulties | _____ | _____ | Do you have a Pacemaker? | _____ | _____ |
| Weight Loss/Energy Loss | _____ | _____ | Shortness of Breath/Chest Pain | _____ | _____ |
| Numbness or Tingling | _____ | _____ | Coronary Heart Disease or Angina | _____ | _____ |
| Weakness | _____ | _____ | Congestive Heart Disease | _____ | _____ |
| Dizziness or Fainting | _____ | _____ | Stroke/TIA | _____ | _____ |
| High Blood Pressure | _____ | _____ | Blood Clot/Emboli | _____ | _____ |
| Bowel or Bladder Problems | _____ | _____ | Varicose Veins | _____ | _____ |
| Emotional/Psychological Problems | _____ | _____ | Anemia | _____ | _____ |
| Thyroid Disease or Goiter | _____ | _____ | Joint Replacement Surgery | _____ | _____ |
| Epilepsy/Seizures | _____ | _____ | Any Pins or Metal Implants? | _____ | _____ |
| Cancer or Chemotherapy/Radiation | _____ | _____ | Do you use tobacco? | _____ | _____ |
| Sleeping Problems/Difficulties | _____ | _____ | Are you pregnant? | _____ | _____ |
| Diabetes | _____ | _____ | Leg/Ankle/Foot: <input type="checkbox"/> Injury <input type="checkbox"/> Surgery | _____ | _____ |
| Infectious Diseases | _____ | _____ | Shoulder: <input type="checkbox"/> Injury <input type="checkbox"/> Surgery | _____ | _____ |
| Arthritis | _____ | _____ | Elbow/Hand: <input type="checkbox"/> Injury <input type="checkbox"/> Surgery | _____ | _____ |
| Osteoporosis | _____ | _____ | Neck: <input type="checkbox"/> Injury <input type="checkbox"/> Surgery | _____ | _____ |
| Gout | _____ | _____ | Back: <input type="checkbox"/> Injury <input type="checkbox"/> Surgery | _____ | _____ |
| Hernia | _____ | _____ | Knee: <input type="checkbox"/> Injury <input type="checkbox"/> Surgery | _____ | _____ |

Smoking Status: Every Day Smoker Some Days Smoker Former Smoker Never Smoker Unknown

List any other information that would assist us in your care, i.e. recent surgeries, etc.:



Patient Medical History

Are you aware of your diagnosis and prognosis as explained by your doctor? YES NO

Based on your awareness, what are your rehabilitation expectations/goals while in this program?

Would you like to speak to a social worker about any aspects of your rehabilitation program? YES NO

Please list the following Medications you are taking below:

| Drug Name <i>(including OTC, herbals, vitamins)</i> | Dosage <i>(mg, units, etc.)</i> | Frequency <i>(once a day, etc.)</i> | Route <i>(oral, topical, etc.)</i> |
|--|------------------------------------|--|---------------------------------------|
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Are you allergic to any medications? YES NO

If yes, list Medications: _____

Patient/Guardian Signature: _____

Date: _____

| |
|---------------------------------------|
| OFFICE USE ONLY |
| Intake Reviewed by: _____ Date: _____ |