# Absolute Rehab Therapy

**Patient Registration – Auto Accident**

Today's Date: ____/____/____

Patient Name: _____ Date of Birth: _____/_____/____ Sex: M/F

Address: _____ City/State: _____ Zip: _____

Phone #: _____ Email: _____

Primary Care Doctor: _____

**Office Use ONLY:**

**Initial Exam: ____/____/____ Provider: _____ New Patient: Y N**

## Accident Information

Date Accident Occurred: ____/____/____Time of Day when Accident Occurred: _____ AM/PM

Describe how the Accident took place:

_____

_____

_____

_____

Describe the condition or symptoms caused by the Accident:

_____

_____

_____

_____

## Auto-Accident Insurance Information:

Auto Insurance: _____ Id #: _____ Claim Adjustor (If known): _____ Phone #: _____

Claim # (If known): _____

## Auto-Accident Specific Information:

Were you the: Driver_____ Passenger_____ Pedestrian_____

Automobile you were in: Year_____ Make_____ Model_____

Damage to your car: Front_____ Rear_____ Pedestrian_____ Driver Side_____ Passenger Side_____ Bumper_____ Fender_____

Damage Amount Estimate: $_____ Minor_____ Major_____ Totaled_____

Other Automobile: Year_____ Make_____ Model_____

Damage to other car: Front_____ Rear_____ Pedestrian_____ Driver Side_____ Passenger Side_____ Bumper_____ Fender_____

Minor_____ Major_____ Totaled_____

Where did the accident occur? Street Names:_____
City/State_____

Was it? Controlled Intersection_____ Uncontrolled_____ Not an Intersection_____

Was there a traffic light? None_____ Green_____ Red_____ Turn Arrow_____ Stop Sign_____

Were you: Slowly Moving_____ Moving_____ Stopped_____

Weather Conditions: Sunny_____ Rainy_____ Cloudy_____ Fog_____

Street Surface: Dry_____ Wet_____ Slick_____ Icy_____ Pavement_____ Other_____

Type of Impact: Rear end_____ Front_____ Side Impact_____ Roll Over_____

Brakes on Impact: Locked Tight_____ Loosely Applied_____ Foot not on brake_____

How far did your car move? Did not move___ Moved 1-5 FT___ Moved 6-10 FT___ Moved 10+ FT___

Where were you seated in the vehicle: _____ Seatbelt: Y N

Shoulder harness: Y N Headrest Y N Headrest Position: Up____ Down____

Was the car equipped with airbags? Y N Did they deploy? Y N

Did you see the impact coming? Y N Did you brace yourself for impact? Y N

On impact, your head was looking: Ahead____ Behind_____ Up_____ Down_____ To the right_____ To the left_____

Om impact were you: Thrown forward_____ Thrown Backward_____ Thrown sideways_____
Other_____

Did your body hit anything inside the car? Y N Body Part:_____

What did it hit? _____

Head trauma? Y N Loss of Consciousness? Y N For how long? _____

Do you remember the accident happening? Y N

Hospital? Y N Name of Hospital: _____ How long was stay?_____

Taken by Ambulance? Y N

Were X-rays taken? Y N X-ray area: Neck____ Mid-back____ Low-back____ Other_____

Were MRIs taken? Y N

Medication given? Y N RX:_____

Other instruction: _____ Follow-up:_____

## Additional Information Related to the Condition:

Describe your pain: Burning_____ Sharp_____ Dull_____ Ache_____

What caused it? _____

What aggravated it? _____

What relieves it?

_____

Have you had the same or a similar condition or symptoms previous to recent occurrence? Y N

When? ____/____/____

Describe:

_____

_____

_____

_____

Please indicated any other healthcare providers who you are seeing or have seen for the condition or symptoms:

| Name | Type of Licensure | Date of Last Visit |
|---|---|---|
| _____ | _____ | ____/____/____ |
| _____ | _____ | ____/____/____ |

Please check all that you are experiencing now:

Headache___ Dizziness___ Light Bothers Eyes___ Diarrhea___ Head seems heavy___

Neck Pain___ Loss of Memory___ Clumsiness___ Feet Cold___ Neck Stiff___

Tingling in arms/hands___ Ears Ring___ Hands Cold___ Sleeping Problems___

Tingling in legs/feet___ Face Flushed___ Nausea___ Back Pain___ Numbness in arms/hands___

Buzzing in Ears___ Constipation___ Nervousness___ Numbness in legs/feet___

Loss of Balance___ Cold Sweats___ Tension___ Shortness of Breath___ Fainting___ Fever___

Fatigue___ Irritability___ Loss of Smell___ Chest pain/rib pain___ Pain in arms/hands___

Pain in legs/feet___ Jaw Pain___ Loss of strength-arms___ Burning muscle pain___

Loss of strength-legs___ Difficulty swallowing___ Sharp/shooting pain___

Other_____

Have you experienced changes to:

Eyes (sight)___ Ears (hearing)___ Nose (smell)___ Mouth (taste)___ Bladder___ Bowels___

Sleep___ Emotion___ Appetite___

Please Explain further: _____

Have you missed work or school due to your injuries? Y N

Do you smoke? Y N Number of packs per day:_____

Do you drink alcohol? Y N Number of Drinks:_____

Notes:_____

_____

_____

# Absolute Rehab Therapy

Medical History
(PLEASE PRINT CLEARLY)

**Name:** _____

**Have you had, or currently have any of the following? Please Mark ONLY if yes**

## MEDICAL HISTORY

| | | |
|---|---|---|
| Allergies ☐ | Gallbladder Problems ☐ | Nausea ☐ |
| Anemia ☐ | Gout ☐ | Numbness ☐ |
| Anxiety ☐ | Headaches ☐ | Osteoporosis ☐ |
| Arthritis ☐ | Hepatitis ☐ | Pacemaker ☐ |
| Asthma ☐ | Hearing Difficulty ☐ | Parkinson's ☐ |
| Blood Clots ☐ | Heart Attack ☐ | Rheumatoid Arthritis ☐ |
| Cancer ☐ | Hernia ☐ | Seizures ☐ |
| Cardiac Condition ☐ | High Blood Pressure ☐ | Sinus Problems ☐ |
| Circulation Problems ☐ | High Cholesterol ☐ | Sleeping Disorders ☐ |
| Currently Pregnant ☐ | Infectious Disease ☐ | Smoker ☐ |
| Dementia ☐ | Joint Replacements ☐ | Speech Problems ☐ |
| Depression ☐ | Kidney Disease ☐ | Strokes ☐ |
| Diabetes ☐ | Liver Disease ☐ | Thyroid Disease ☐ |
| Dizzy Spells ☐ | Loss of Balance ☐ | Tuberculosis ☐ |
| Emphysema ☐ | Low Blood Pressure ☐ | Vision Problems ☐ |
| Epilepsy ☐ | Metal Implants ☐ | Weakness ☐ |
| Fibromyalgia ☐ | Multiple Sclerosis ☐ | |

**Please list any other conditions that are not listed here on the back or a separate sheet of paper**

## Fall History

Injury as a result of a fall in the past year? ☐ Yes ☐ No Date of fall: _____

Two or more falls in the last year? ☐ Yes ☐ No Date of falls: _____

## Surgical History

Body Region: _____ Surgery Type: _____ DOS: _____

Body Region: _____ Surgery Type: _____ DOS: _____

Body Region: _____ Surgery Type: _____ DOS: _____

Body Region: _____ Surgery Type: _____ DOS: _____

**List additional surgeries on back or separate sheet of paper**

## Current Medications

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

**6971 N. Federal Hwy, Suite 305, Boca Raton, FL 33487 Office: 561-241-4411 Fax: 561-241-4411**
**e-mail: absoluterehabtherapy@gmail.com**

# Absolute Rehab Therapy

Medical History

(PLEASE PRINT CLEARLY)

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

**List additional medications on back or separate sheet of paper**

**Allergies**

_____

_____

Patient's Signature: _____ Date: _____

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# Absolute Rehab Therapy

## Medical Screen

**Patient Name:** _____ **D.O.B:** ____/____/_____

**Sex:** ☐M ☐F **Height:** _____ **Weight:** _____ **Blood Pressure:** _____/____mmHg

**Where are you currently having symptoms?**

_____

**Date of injury or onset of symptoms?** _____

**Have you been treated for this/these problems in the past?** ☐Yes ☐No if yes, when and where? _____

**Have you had surgery related to this/these problems in the past?** ☐Yes ☐No if yes, type and date: _____

**Have you had any of the following Medical/Rehabilitation services for this problem?** (Check ALL that apply)

| | | |
|---|---|---|
| ☐ Chiropractor | ☐ MRI | ☐ Orthopedist |
| ☐ CT Scan | ☐ Myelogram | ☐ Physical Therapist |
| ☐ ER Care | ☐ Neurologist | ☐ Podiatrist |
| ☐ Massage Therapy | ☐ Occupational Therapist | ☐ X-Ray |

**Are you aware of what your diagnosis is?** ☐Yes ☐No if yes, what: _____

**Based upon your awareness, what are your expectations/goals?** (i.e.: improve ability to....;decrease pain with...)

**Type of pain** (Check maximum of 2):

| | |
|---|---|
| ☐ Aching | ☐ Sharp |
| ☐ Burning | ☐ Shooting |
| ☐ Dull | ☐ Other |

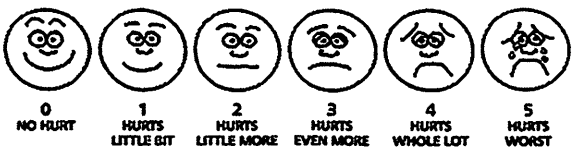
**Please check ALL that apply below:**

☐ Headaches: _____x/week
☐ Numbness
☐ Tingling
☐ Weakness

**Frequency of Pain** *How often do you have this pain?*

_____x/week ☐ every A.M ☐ every P.M With Activity? ☐Yes ☐No

**Intensity of Pain** *Please indicate which number best describes your pain intensity: #* _____




**My pain is increased by:**

_____

**My pain is decreased by:**

_____

**Patient Signature:** _____ **Date:** _____

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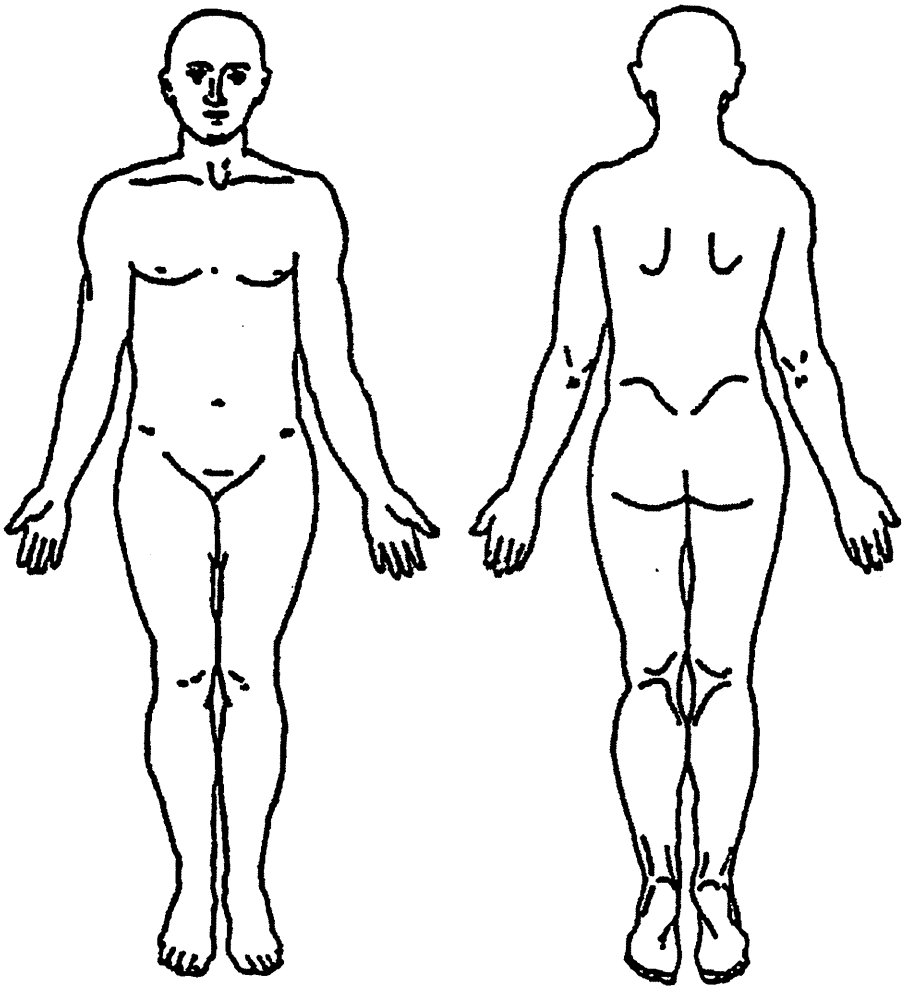
# Absolute Rehab Therapy



**Pain/Symptoms**

- Please mark your pain on an average day by marking a number on the scale below.

**0----------10**
**No Pain** **ER Visit**

- On the Body Diagram above, describe your symptoms using the following symbols:

**(X) Sharp (+) Numb/Tingling (#) Ache (B) Burning**

Patient's Signature: _____ Date: _____

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# Absolute Rehab Therapy

Consent for Care and Treatment

*Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used.*

› **I, the undersigned, do hereby agree and give my consent for Absolute Rehab Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical conditions.**

› **INITIAL** _____

- **Workers Compensation Claims:** Prior authorization/approval is needed before any treatment or therapy can be performed. Failure to have proper authorization may result in your claim for Workers Comp benefits being denied and you will be held responsible for the total charges or fees for services rendered.
- **PIP Claims:** (Auto Insurance) Your auto insurance commonly covers 80%/ The remaining 20% will be billed to you once the claim is processed and paid for you by insurance. If your benefits have been exhausted, your claims will be billed to your insurance company. If your claim is part of a law suit, the 20% will be held over until the case settles and payments are then determined by a negotiation process.

› **INITIAL** _____

❖ **FINANCIAL POLICY:**

You are responsible for your bill, as we are out of network on all insurances other than Medicare. We will bill your personal insurance carrier solely as a courtesy to you. If you change insurance coverage while undergoing treatment, it is your responsibility to notify the office of this change. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If the insurance company for services billed by us make any payment directly to you, you recognize an obligation to promptly remit the payment(s) to us. If formal collection procedures become necessary you will be responsible for additional costs incurred. Your insurance policy is a contract between you and your insurer and most information regarding your benefits are located in your plan booklet or you can check with your insurance company. We assume no liability for any errors made by your insurance carrier.

***We will verify your insurance benefits and coverage on your behalf but please note that benefits and coverage is not a guarantee of payment and you are ultimately the responsible party of all fees for services rendered.***

- **CO-PAYMENTS:** Co-payments are due at the time of service unless prior arrangements have been made in writing.
- **INSUFFICIENT FUNDS:** Checks returned for insufficient funds may be subject to a **$35.00** processing fee.

› **CANCELLATION and NO-SHOW POLICY:** We require 24 hours' notice in the event of a cancellation. The charge for cancellation without prior notice is $65.00. This charge will not be covered by insurance but will have to be paid by you personally prior to receiving additional treatments.

**Patient Name:** _____

**Patient Signature:** _____ **Date:** _____

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Absolute Rehab Therapy
A.R.T. in Motion

# Patient Scheduling Preferences

**Patient Name:** _____

At Absolute Rehab Therapy, we do our best to accommodate your physical therapy appointments with your personal schedule. *Please understand your appointments are pertinent to your treatment plan in meeting your physical therapy goals.*

**NOTE: The frequency of appointments can only be determined *after* completion of your initial evaluation.** The frequency may be 3 times a week for the initial appointments, but will most likely be 2 times a week for the majority of your treatment plan.

**Please fill out the schedule to designate your scheduling preferences, using the key symbols:**

[X] Days/times in which you will be **NOT AVAILABLE**
[1] Your **1st** choice for appointment days/times (2 x week)
[2] Your **2nd** choice for appointment days/times (2 x week)

| | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| 8:00am-9:00am | | | | | |
| 9:00am-10:00am | | | | | |
| 10:00am-11:00pm | | | | | |
| 11:00pm-12:00pm | | | | | |
| 1:00pm-2:00pm | | | | | |
| 2:00pm-3:00pm | | | | | |
| 3:00pm-4:00pm | | | | | |
| 4:00pm-5:00pm | | | | | |

**If there are any ***specific dates*** in which you will **not be available** (i.e.: vacations, doctor appointments) please write them below:

_____

_____

_____

# Absolute Rehab Therapy
# A.R.T. in Motion

## Medical Record Release Form

**I hereby authorize the following information to be released from the medical record of:**

**Patient Name:** _____

**DOB:** _____

**Address:**

_____

_____

**Phone #:** _____

_____ **I request that my information be released to Absolute Rehab Therapy from**

**Doctor Name/Name:** _____

**Fax #:** _____

**Requesting:** _____ **Release of Insurance/Benefit information**

_____ **Medical Records**

_____ **Surgical Records**

_____ **MRI/CAT Scan Reports**

_____ **X-Rays**

_____ **Requesting updated prescriptions**

**Signature** _____ **Date:** _____

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Absolute Rehab Therapy
A.R.T. in Motion

# DIRECTIONS

**Absolute Rehab Therapy**
6971 N. Federal Highway Ste 305
Boca Raton FL 33487
Ph: 561-241-4411
Fax561-241-4211

**From the North**:
I-95 South or Jog Rd. to Linton Blvd
Take Linton East to Old Dixie Road or Federal Highway (US 1)– Take a RIGHT turn (south) onto Old Dixie Road or Federal Hwy.

**From Old Dixie:** Go Past Lindell AND Hidden Valley (Both are Traffic Lights). Make a left into 6971 **Boca Palm Professional Plaza.**

**From Federal:** Go Past Lindell AND Hidden Valley (Both are Traffic Lights). Make a RIGHT turn into 6971 **Boca Palm Professional Plaza** (Entrance is between Tuscany Condominiums and building 7001. We are directly across the street from ABC Liquor

**Alternate North Route:**
Take Congress Ave N and make a left-hand turn at SW 10th Ave. Take SW 10th Ave all the way down to Old Dixie Road. Take Old Dixie Road and pass Linton, Lindell AND Hidden Valley (Traffic Lights). Best for early AM or later PM appointments to avoid high volume traffic.

**From the South**
I-95 North to Yamato Road
Take Yamato East to N. Dixie Hwy – Take a LEFT turn (north) onto Dixie Hwy. About 1 mile up the road on the right just past the Tuscany condominiums and right before Old Dixie Seafood–
Take a RIGHT turn into 6971 **Boca Palm Professional Plaza**

**** Our office is located on the ground floor.****

**A map can be found on our website:www.absoluterehabtherapy.com The link indicating '*office location*' can be found at the top of the page.**