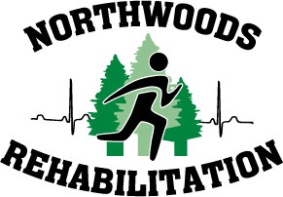
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**WELCOME TO OUR PRACTICE**Patient Questionnaire

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| **Patient Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| PatientLast Name: | | | | | | | | | | | | First: | | | | | | | | | | | | | Middle Initial: | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Social Security Number: | | | | | | Referring Physician: | | | | | | | | | | | Primary Care Physician: | | | | | | | | Today’s Date: | | |
| Street Address: | | | | | | | | | | | | | | | | City: | | | | | | | | State/Zip: | | | |
| Home Phone:  ( ) | | | | Cell Phone:  ( ) | | | | | | | | | | Work Phone:  ( ) | | | | | | Best time and place to reach you. | | | | | | | |
| My condition is related to:  Work Injury  Auto Accident (State )Other | | | | | | | | | | | | | | | | | | | | | | | | | | | Date of Onset: |
| Sex:  M  F | Age: | | Date of Birth: | | | | | | | Marital Status:  Single  Married Widowed Minor Other | | | | | | | | | | | | | | | | | |
| Occupation: | | | | | | | | | | | | | | | Employer/School Name: | | | | | | | | | | | | |
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| **Emergency Contact** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Emergency Contact: | | | | | | | Phone: | | | | | | Relationship to Patient: | | | | | | | | Spouse’s Name: (if different than emergency contact) | | | | | | |
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| **Medical Insurance Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of Insurance Company:  Please Provide Copy of Card | | | | | | | | | Name of Primary Insurance Holder: | | | | | | | | | | | | | Birth Date of Primary Ins. Holder: | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
| **Signatures**  I certify that I have insurance coverage and assign directly to Northwoods Rehabilitation all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  *Patient Signature Date* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Health History** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Check all symptoms or conditions that you have seen a physician for or have been treated for in the past year.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Diabetes  Tumor  Stroke  COPD | | | | | |  | | | Blood Pressure  Thyroid Condition  Heart Problem  Cancer  If yes, what kind? | | | | | | |  | Blood Clots  Anxiety  Bleeding Disorder  Other | | | |  | | | Asthma  Arthritis  Seizure | | |
| **Are you pregnant?** Yes  No**Do you have a pacemaker?**  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Do you have any metal implants?** Yes  No  If yes, please list | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Have you had any surgeries?** Yes  No  If yes, please list  **Do you have any allergies?** Yes  No  If, yes please list  **Have you ever had a skin reaction to adhesive tape?** Yes  No  **Please list any medications you are currently taking.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referral Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Please tell us how you heard about us. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TV  Radio  Newspaper | | | | | Family or Friend  Physician’s office  Other | | | | | | | | | | | | | | | | | | | | | | | |

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| **Patient Condition**  **Please fill this section in as complete as possible. Include any additional information as necessary.** | | | | | | | |
| Name: | | | | | | Age: | Today’s Date: |
| **What is the primary problem or chief complaint that you would like addressed in therapy?** | | | | | | | |
| **Date of onset:** | **Recent tests:**  x-rays  CT  MRI | | **Please list any known results from recent tests.** | | | | |
| Please circle **current** pain:  0 1 2 3 4 5 6 7 8 9 10  No pain Severe pain | | | | | | | |
| **What is your highest pain rating in the last 3 days?** | | **Lowest pain rating?** | | | **Does the pain wake you at night?** Yes  No | | |
| **For the following questions, please check all that apply or fill in words that describe your condition.**  1. What makes your pain worse?  Sitting  Standing  Walking  Exercise   2. What makes your pain better?  Sitting  Lying down  Heat  Ice  Medications  3. Are your symptoms getting progressively  Better  Worse  Same | | | | | | | |
| **Please indicate on the diagram the location of your current pain and describe your pain below.**  (Please check all that apply) | | | | | | | |
| Sharp Dull Ache Stabbing Numbness  Shooting  Throbbing  Tingling  Pulling  Tight  **Which best describes your symptoms?**  (Please check one.)  Constant  Intermittent (relieved with some positions or rest)  Occasional (daily or less frequent)  Variable (sometimes worse than other times) | | | |  | | | |
|  | | | | | | | |
| **What are your current goals for therapy?**  (Check all that apply.)  Return to work  Increase motion  Increase strength Increase function  Improve balance  Improve walking ability  Decrease pain  Other | | | | | | | |

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| **Notice of Privacy Practices**  **Patient Acknowledgement** | | | |
| **Name**: | **Date of Birth**: |  |
| I have received this practice’s Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice’s legal duties with respect to my protected health information. The Notice includes:   * A statement that this practice is required by law to maintain the privacy of protected health information. * A statement that this practice is required to abide by the terms of the notice currently in affect. * Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations. * A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization. * A description of uses and disclosures that are prohibited or materially limited by law. * A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization. * My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to: * The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.   + - * + The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.         + The right to receive confidential communications of protected health information.         + The right to inspect and copy protected health information.         + The right to amend protected health information.         + The right to receive an accounting of disclosures of protected health information.         + The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.   This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice’s current Notice of Privacy Practices on request.  **Signature**: **Date**:  **Relationship to patient** (if signed by a personal representative of the patient): | | | |