ProRehab

Patient Registration Form

First Name: ____________________ MI: ________ Last Name: ____________________

Address: ______________________________ City: ____________________

State: __________ Zip code: ______________ SS number: ____________________ Date of birth: ________________

Please check all the ways we can contact you

☐ Home phone: ____________________ ☐ Cell phone: ____________________ ☐ SMS/Text on cell

☐ E-mail address: ______________________________ ☐ Work phone: ____________________

Please keep in mind that communications via email over the internet is not a secure form of communication.

Employer and Employer phone number: ____

Who is your General Physician: ____

2nd contact person name/address: ____

Phone Number: ____________________ Relation: ____________________

Please Fill Out The Following Information If Different From Above

Primary

Policy holder information: ____
(name, address, Insurance plan name)

Policy holder DOB: ________________ ID/SS#: ____________________ Group number: ____________________

Secondary

Policy holder information: ____
(name, address, Insurance plan name)

Policy holder DOB: ________________ ID/SS#: ____________________ Group number: ____________________

Is this work related? Yes No **If yes**, Date of Injury: ______________________________

Employer address: ____

Is this Motor Vehicle Accident related? Yes No **If yes**, State ____________ and Date of accident: ________________

How did you hear about us? ☐ Physician Referral, who referred ____________________ ☐ Family or Friend

☐ Industry ☐ Advertisement (please list) ________________ ☐ Other (please list) ____________________

I hereby authorize and consent to treatments/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 physician.

I assign medical benefits payable for these services directly to ProRehab. I authorize the release of any medical or other information necessary to process claims for these services.

I understand that I am responsible for payment of any applicable co-payments, co-insurance, deductibles or non-covered services at the time of service. In Medicare assigned cases, ProRehab participates in the Medicare program and accepts Medicare's allowed amount for covered services, less any co-pay, co-insurance, deductible or non-covered services.

In signing this form I acknowledge that I am responsible for the bill not paid by the insurance carrier.

I understand that my health information will be used for treatment, payment and healthcare operations, (see the Notice of Privacy Practice).

By providing your contact information, you agree to receive information, such as appointment reminders, patient surveys and other information relating to your therapy services via the communication channels you provided above.

____ ____________________

Patient/Legal Guardian Signature Date

Relationship to Patient: ____

__________ I acknowledge receipt of the Notice of Privacy Practices which provides information on how my Protected Health Information may
Initial be used or disclosed, if I have any questions I can contact the Compliance Department.

ProRehab

MEDICAL HISTORY FORM

PATIENT NAME: ____ Acct#: ____________________

Please check if you have been diagnosed with any of the following conditions:

_____Diabetes(I/II)	_____Heart Disease	_____High Blood Pressure	_____Cancer
_____Pacemaker	_____Stroke (TIA or CVA)	_____Seizures	_____Metal Implants
_____Back Pain	_____Circulation problems	_____Osteoporosis	_____Stomach ulcers
_____Broken bones	_____Respiratory Problems	_____Depression	_____Asthma
_____Blood Clots	_____Rheumatoid Arthritis	_____Thyroid Problems	_____Kidney problems

_____Infectious Diseases (HIV, Hepatitis, TB, etc.) ____

_____Other: ____

Surgical History: ____

Have you recently noted? Check all that apply:

_____Nausea/Vomiting	_____Dizziness spells	_____Pain at night	_____Currently pregnant
_____Unusual weakness	_____Visual problems	_____Heart Palpitations	_____Hearing problems
_____Bleeding	_____Difficulty walking	_____Joint pain or swelling	_____Fever/chills/sweats
_____Chest Pain	_____Shortness of breath	_____Incontinence	_____Productive/Chronic Cough
_____Difficulty sleeping	_____Loss of Appetite	_____Unexplained weight changes	_____Fatigue or myalgia

Have you recently traveled out of the country? ☐ Yes ☐ No

Have you had direct prolonged contact with someone with confirmed case of coronavirus? ☐ Yes ☐ No

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

Please list all, both prescribed and over the counter medications you are currently taking, include name, dosage, frequency, route taken:

____

____

____

Sex: ☐ Male ☐ Female **Height:** ____________ **Weight:** ____________

Are you: ☐ Right handed ☐ Left handed

Do you have any allergies? ☐ Yes ☐ No If yes, please list: ______________________________

With whom do you live:

☐ Alone ☐ Spouse only ☐ Spouse and others ☐ Child ☐ Other ______________________________

Where do you live:

☐ Private home ☐ Apartment/rented room ☐ Assisted living/group home ☐ Hospice ☐ Other____________________

Does your home have:

☐ Stairs, no railing ☐ Stairs, railing ☐ Ramps ☐ Uneven terrain

Please explain: ____

Employment/Work (Job/School/Play):

Working: ☐ Full time ☐ Part time ☐ Retired ☐ Unemployed ☐ Occupation: ____________________________

PATIENT NAME: ____

General Health Status, Please rate your health; ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of onset of current symptoms/injury: Month _________ **Day** _________ **Year** ____________

Describe the problem(s) for which you seek therapy: ____

____

Explain how problem(s) occurred: ____

____

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

What makes the problem(s) better? ____

What makes the problem(s) worse? ____

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

____

What are your goals for therapy? ____

Have you ever had the problem(s) before? ____

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, etc. for this problem? If so, what were the results

____

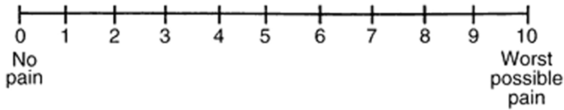
Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No

If yes, please tell us what it is: ____

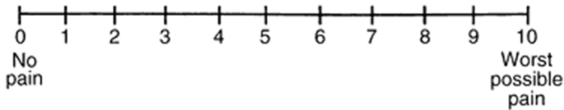
Pain Rating:

If you have pain, what is your pain level? Please Circle

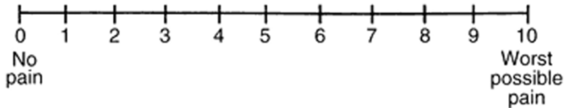
CURRENT Pain



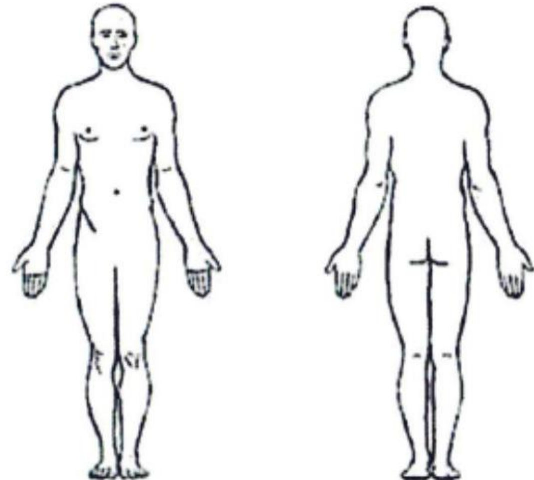
Pain level at **BEST**



Pain level at **WORST**



Please mark the location of pain with an "X"



To the best of my knowledge the above information is accurate and complete.

Signature: ____ **Date:** ____________________

Thank you for completing this questionnaire. It will allow us to better serve your needs.

Therapist Signature: ____ Date: ___________________