PATIENT INFORMATION

Name: _____ Date of Birth: _____/_____/_____

Address: _____

Age: _____ S.S.#: ____-_____-_____ Gender: Male Female Spouse Name: _____

HomePhone: _____ Cell Phone: _____ Texts? Yes or No

Email Address: _____

How did you hear about us? Dr._____ Insurance Friend Family Other _____

GUARANTOR INFORMATION

Name: _____ Phone: _____

Address: _____ ☐ Same as patient

WORK INFORMATION

Employer: _____ Occupation: _____

Work Phone: _____ Employment Status: Full-Time Part-Time Retired Unemployed

CARE PROVIDER INFORMATION

Referring Dr: _____ Dr. Phone Number: _____

Primary Dr./PCP: _____ Dr. Phone Number: _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name: _____

Subscriber's Name (If different): _____ ID. #: _____

Patient's Relationship to Subscriber: _____

Name of Secondary Insurance: _____

Subscriber's Name: _____ ID. #: _____

Patient's Relationship to Subscriber: _____

ATTORNEY INFORMATION/LETTER OF PROTECTION

Name: _____ Law Firm: _____

Address: _____ Phone Number: _____

Is this a work or auto related injury? Yes or No

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address): _____

Relationship to Patient: _____ Phone Number: _____

I authorize my insurance benefits be paid directly to Team Concept Rehabilitation. I understand that I am financially responsible for any balance. I also authorize Team Concept Rehabilitation to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE _____ DATE _____

TEAM CONCEPT REHABILITATION

PAST MEDICAL HISTORY

BLOOD PRESSURE	YES	NO
Hypertension		
Low Blood Pressure		
Normal Blood Pressure		

HEART DISEASE	YES	NO
Heart Attack		
Atherosclerotic Disease		
Myocardial Infarction		
Rheumatic Heart Disease		
Heart Murmur		
Do you have a pacemaker?		

MUSCLE CONDITION	YES	NO
Carpal Tunnel		
Tendinitis		
Back/Neck Problems : R / L		
Limited Limb Movement		

LUNGS	YES	NO
Asthma		
Emphysema		
Shortness of Breath		

JOINT CONDITIONS	YES	NO
Upper Extremity Dislocation		
Lower Extremity Dislocation		
Osteoarthritis		

OTHER CONDITIONS	YES	NO
Muscular Dystrophy		
Gout		
Hearing Loss		
Poor Eyesight		
Fainting		
Polio		
Diabetes		
Fibromyalgia		
Rheumatoid Arthritis		
Multiple Sclerosis		
Cancer		
Epilepsy		
Other		

EXERCISE

None 1-2 x Week 3-4 x Week 5+ x Week

What types of exercise do you perform? : _____

_____

WORK ACTIVITY Sitting Standing Light Labor Heavy Labor

STRESS LEVEL Low Medium High

List stressors : _____

HABITS

Smoking: _____ Packs a Day | Alcohol: _____ Drinks a Week | Coffee/Soda: _____ Cups a Week

Are you taking any seizure medication? _____ Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy? _____

If so, please list: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? _____ What week?: _____

Have you had any injuries related to work? _____ Have you had any Auto Accidents? _____

Have you had Physical Therapy before? _____

_____ _____

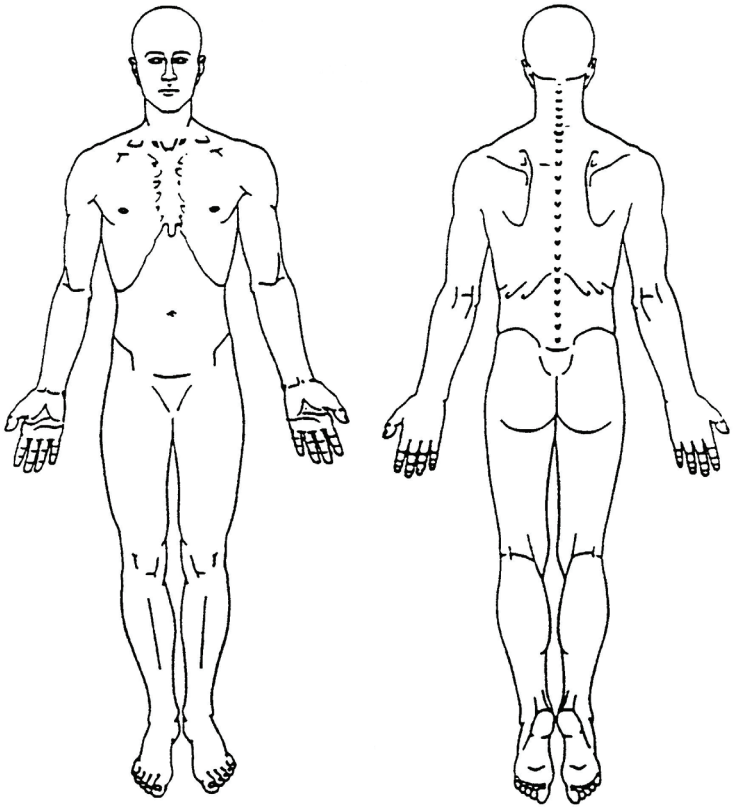
Signature of Patient, Parent, Guardian, Personal Representative Date

PAIN AND SYMPTOMS REPORT

Name: _____ Date: _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

Ache **MMMMM**	**Pins & Needles** **XXXXXX**
Burning **OOOOO**	**Numbness** **/////**
Stabbing **-----**	**Other** **^^^^^**



CHEIF COMPLAINT AND VISUAL ANALOG SCALE

My Chief Complaint is: _____

Date First Symptom of Your Problem Occurred on: _____

2nd Complaint :_____

3rd Complaint: _____

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10

Additional Comments: _____

_____

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as Team Concept Rehabilitation or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information. If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

_____

Name of Patient (Print Clearly)

_____

Signature of Patient Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient