RehabOne
Orthopedic and Sports Physical Therapy

Date:_____

NEW-PATIENT INFORMATION

Patient Name: _____ Social Security #:_____-_____-_____

Nickname: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female Email: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

School/Employer: _____ Occupation: _____

Person Responsible for Bill: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Referring Physician: _____ when is your next Doctor Appointment: _____

Date of onset (injury, accident, surgery date or date symptoms started or worsened):_____

Have you had any Physical/Occupational Therapy this calendar year? Check one: ☐ **YES** ☐ **NO**

If yes: (List Company Name) _____
HOW MANY VISITS COMPLETED? _____

MEDICARE PATIENTS: Are you currently enrolled in Home Health? Check one: ☐ **YES** ☐ **NO**

If yes: (List Company Name) _____

Date:_____

Medical Screening Questionnaire

Name: _____ Gender: M F Age: _____ Date of Birth:_____

Smoker: Y N How much? _____ (a day) **Pregnant:** Y N **Pacemaker:** Y N

Drink Alcohol: NEVER OCCASIONALLY FREQUENTLY

Surgical history & dates: _____

_____

List all medications: _____

_____

_____

Have you had an x-ray, MRI, or other study regarding your condition? Y N

Please circle each condition that you have been told you have (or had):

Cancer	High Blood Pressure	Heart Disease	Liver Disease
Stroke	Angina/Chest Pain	Osteoarthritis	Osteoporosis
Ulcers	Fibromyalgia	Rheumatoid Arthritis	Metal Implants
Diabetes	Lung Disease	Allergies	

Have you had any other recent illness?_____

Are you allergic to latex? Y N **Do you take blood thinners? Y N**

I currently have: (circle all that apply):	Fever/chills/sweats	Poor balance (falls)
Unexplained weight loss	Numbness/tingling	Difficulty swallowing
Shortness of breath/dizziness	Headaches	Changes in appetite
Changes in bowel & bladder function	Nausea/vomiting	Increased pain at night

Current Symptoms

Where are you having symptoms? _____

What date (approximate) did your present pain start? _____

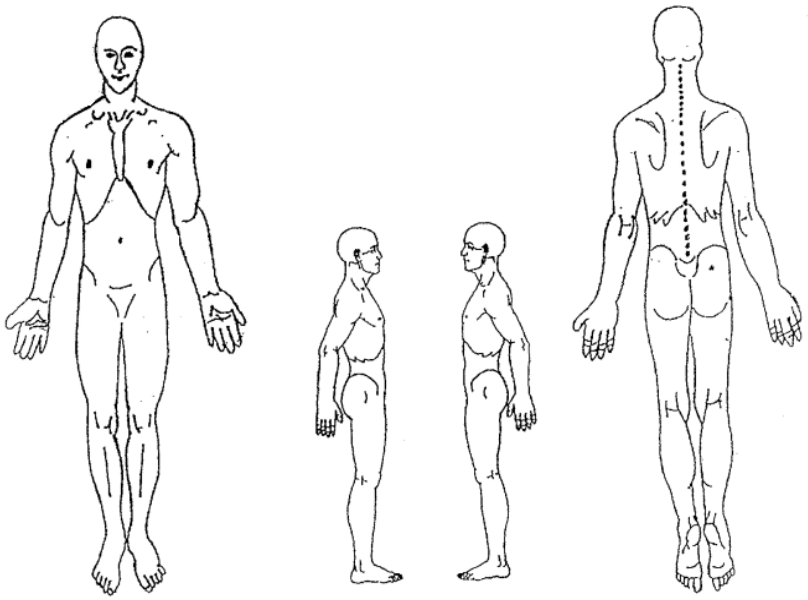
How (gradually, suddenly, injury)?: _____

My symptoms are: Getting better About the same Getting worse

Have you received any treatment for this problem? _____

Have you ever had the problem before? Y N Previous treatment?: _____

How are you sleeping at night? Fine Moderate difficulty Only with medicine



Please mark the areas where you feel pain, numbness or other symptoms on the body chart.

Key:

O ---Pain

□ ---Numbness

On the scales below, please circle the number which best represents the severity of your pain

Average for the last 48 hours:

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worst pain imaginable**

Best for the last 48 hours:

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worst pain imaginable**

Worst for the last 48 hours:

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worst pain imaginable**

Please circle the number below that represents your overall average level of function

Cannot do anything	0	1	2	3	4	5	6	7	8	9	10	**Able to do everything**

Please circle the activities that make your pain worse:

Sitting Lying Down Standing Walking Stress

Any other specific activities make your pain worse? _____

What is typically your best time of day? _____ Worst? _____

Aggravating factors: Please identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

_____

_____

_____

RehabOne
Orthopedic and Sports Physical Therapy

Consent to Therapy

1. I have presented myself to this facility for therapy treatments and consent to diagnostic procedures and care provided by my attending therapist.

2. I realize I have the right to refuse any drugs, treatments or procedures to the extent permitted by the law. I acknowledge that medicine is not an exact science; no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical records kept by this facility may be used for educational administrative, and/or facility-approved purposes when my personal identity will not be revealed.

3. I hereby authorize the release of medical information necessary to process my insurance/payer and authorize payments directly to RehabOne, LLC. I authorize medical records to be sent to the referring physician for treatment purposes. RehabOne files my insurance as a courtesy to me. If for some reason they do not pay the claim, I understand it is my responsibility to either work on getting the claim paid by my insurance or pay RehabOne directly. **I have read and FULLY UNDERSTAND the PATIENT FINANCIAL RESPONSIBILITES FORM.**

4. With this consent, RehabOne, LLC may call my home, work, or cell and leave a message in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointments, reminders, insurance items and any calls pertaining to my clinical care. RehabOne, LLC may also mail to my home, or other alternate location, any items that assist the practice in carrying out treatment, payment, and healthcare operations.

5. Workers Compensation—I hereby authorize my rehab consultant/nurse case manager/ adjustor to receive my records related to my work injury.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____

Signature of Patient (or Parent/Guardian if patient is a minor—under 18) **Date**