Patient Information Form

ProRehab
Physical & Occupational Therapy

Patient Information

Last Name _____ First Name _____ MI _____

Address _____

Address 2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____

Address _____

Address 2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____

Date of Injury _____ Last Physician Visit _____

Referred By _____ Latest Referral Information _____

Latest Plan of Care _____

Motor Vehicle Accident _____ That occurred in _____

Primary Insurance

Insurance _____ Deductible _____ Subscriber Name _____

ID _____ Max Benefit _____ Relationship _____

Group # _____ CoPay _____ CoInsurance _____ Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____ Subscriber Name _____

ID _____ Max Benefit _____ Relationship _____

Group # _____ CoPay _____ CoInsurance _____ Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.
(You have the right to refuse to sign this acknowledgment if you so choose.)

Signature _____

ProRehab
Physical & Occupational Therapy

Medication List for ______________________________

Date______________________________

Please list all medications, including all prescriptions, over the counter medications, herbals vitamins and dietary supplements,. Include the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		☐ As needed ☐ Once daily ☐ Twice daily ☐ Three times daily ☐ Other:	☐ Oral ☐ Sublingual ☐ Topical ☐ Subcutaneous Injection ☐ Other
		☐ As needed ☐ Once daily ☐ Twice daily ☐ Three times daily ☐ Other:	☐ Oral ☐ Sublingual ☐ Topical ☐ Subcutaneous Injection ☐ Other
		☐ As needed ☐ Once daily ☐ Twice daily ☐ Three times daily ☐ Other:	☐ Oral ☐ Sublingual ☐ Topical ☐ Subcutaneous Injection ☐ Other
		☐ As needed ☐ Once daily ☐ Twice daily ☐ Three times daily ☐ Other:	☐ Oral ☐ Sublingual ☐ Topical ☐ Subcutaneous Injection ☐ Other
		☐ As needed ☐ Once daily ☐ Twice daily ☐ Three times daily ☐ Other:	☐ Oral ☐ Sublingual ☐ Topical ☐ Subcutaneous Injection ☐ Other
		☐ As needed ☐ Once daily ☐ Twice daily ☐ Three times daily ☐ Other:	☐ Oral ☐ Sublingual ☐ Topical ☐ Subcutaneous Injection ☐ Other
		☐ As needed ☐ Once daily ☐ Twice daily ☐ Three times daily ☐ Other:	☐ Oral ☐ Sublingual ☐ Topical ☐ Subcutaneous Injection ☐ Other

Any additional Medication please write them on the back side

Patient Signature ______________________________

Reviewed by ______________________________

Appointment Reminder Consent

ProRehab

Physical & Occupational Therapy

Complete this form and sign below to give your permission for ProRehab Center Main Clinic to provide automatic appointment reminder service by email or by cell phone text message.

Step One: Select One Option Below

☐ ProRehab Center Main Clinic may send email messages to confirm my upcoming appointments to

Email address:_____

☐ ProRehab Center Main Clinic may send cell phone text messages to confirm my upcoming appointments to
I recognize that normal text messaging rates may apply.

How did you hear about us?

- ☐ Facebook/Social Media
- ☐ Web Search
- ☐ Website
- ☐ Medical Referral: (name)_____
- ☐ Friend/Family: (name)_____
- ☐ Other: _____

_____
Signature of Patient or Guardian

_____
Date

ProRehab
Physical & Occupational Therapy

MEDICAL SYSTEMS REVIEW

Name_____ Date _____

Age _____ Ht _____ Wt _____

Are you latex sensitive? Yes / No Do you smoke? Yes / No Packs/day _____

Do you have a pacemaker? Yes / No

WOMEN – Are you currently pregnant? Yes / No

Have you RECENTLY noted any of the following (check all that apply):

- ☐ Fatigue
- ☐ Fainting/dizziness
- ☐ Coughing/shortness of breath
- ☐ Constipation
- ☐ Falls/loss of balance
- ☐ Skin changes
- ☐ Urine color change
- ☐ Fever/chills/night sweats
- ☐ Nausea/vomiting
- ☐ Heartburn/indigestion
- ☐ Headaches
- ☐ Bleeding/bruising easily
- ☐ Numbness/tingling
- ☐ Weight loss
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Difficulty swallowing
- ☐ Muscle weakness
- ☐ Nail bed changes
- ☐ Infection
- ☐ Other _____

Have you EVER been diagnosed with any of the following (check all that apply):

- ☐ Cancer
- ☐ Depression
- ☐ Thyroid problems
- ☐ Heart/cardiac problems
- ☐ Lung problems
- ☐ Diabetes
- ☐ Chest pain/angina
- ☐ Tuberculosis
- ☐ Osteoporosis
- ☐ High blood pressure
- ☐ GERD/gastrointestinal problems
- ☐ Multiple sclerosis
- ☐ Rheumatoid arthritis
- ☐ Other arthritic conditions
- ☐ Circulation/vascular problems
- ☐ Epilepsy
- ☐ Blood clots
- ☐ Stroke
- ☐ Ulcers
- ☐ Bladder/urinary tract infections
- ☐ Anemia
- ☐ Kidney disease/infection
- ☐ Hepatitis/liver disease
- ☐ Bone or joint infection
- ☐ Asthma
- ☐ Sexually transmitted disease/HIV
- ☐ Pneumonia
- ☐ Pelvic inflammatory disease
- ☐ Spina bifida
- ☐ Lupus
- ☐ Alcoholism
- ☐ Drug dependency
- ☐ Other _____

Has anyone in your immediate family (parents, siblings) EVER been diagnosed with any of the following (check all that apply):

- ☐ Cancer
- ☐ Heart/cardiac problems
- ☐ High blood pressure
- ☐ Depression
- ☐ Osteoporosis
- ☐ Blood clots
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Other _____

During the past month, have you been feeling down or depressed? Yes / No

Do you feel safe in your home? Yes / No