

REHABILITATION WORKS CLIENT INFORMATION /NOTICE OF PRIVACY PRACTICE FORM

PATIENT INFORMATION:

Name: _____ Birth date: _____ Sex: M _____ F _____

Address: _____ City/State: _____ Zip: _____

SSN #: _____ - _____ - _____ Home Ph. #: _____ Work #: _____

Cell Phone #: _____ E-mail : _____

Employer: _____ Employer Address: _____

If patient under 18, name of legal guardian: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you choose Rehabilitation Works? [] Physician [] Friend/Family (name optional): _____

[] Yellow Pages [] Insurance participation [] Geographic location [] Other: _____

PATIENT CARE INFORMATION

Onset of pain/injury/surgery date: (required) _____ Injury Area/Diagnosis: _____

Referring Physician: _____ Primary Care Physician: _____

- Have you had previous therapy this year? YES NO (If YES, Circle: Physical/Occupational/Speech)
- Is this related to an auto accident? YES NO
- Is this a workman's compensation claim? YES NO
- Is this covered under a liability claim? YES NO

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

WORKMAN'S COMPENSATION/AUTO CARRIER: _____

Adjustor/Contact Person: _____ Phone: _____

NOTICE OF PRIVACY PRACTICE

By signing below, I acknowledge that a copy of Notice of Privacy Practices Policy has been made available.

Signature of patient or personal representative

Print patient name

Relationship to patient if signed by a personal representative

Date signed

Office use only: Our Practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our Practice must document its good faith efforts to obtain such acknowledgement and record the reason that the acknowledgement was not obtained.

Refused to sign _____ Physically unable to sign _____ Other _____ Employee Signature: _____ Date: _____

Office use: (revised 1/10) F:\Rach\Rehabilitation Works Client Information Form2010

Client #: _____ Diagnosis: _____ Therapist #: _____ Date: _____

Chief reason for seeking therapy: _____

Previous physical, occupational or speech therapy for this condition? ___ NO ___ YES
If yes, when and where? _____

Previous physical, occupational or speech therapy for a different condition? ___ NO ___ YES
If yes, when and why? _____

Do you have a pacemaker? ___ NO ___ YES
Surgeries or hospitalizations? _____

Medications: _____

Allergies to medications: _____
to latex: _____ to ointments, creams, tape, etc. _____

Females: Is there a possibility that you could be pregnant? ___ NO ___ YES

Next appointment with referring doctor: _____

Please identify any activity with which you are having difficulty or unable to do:

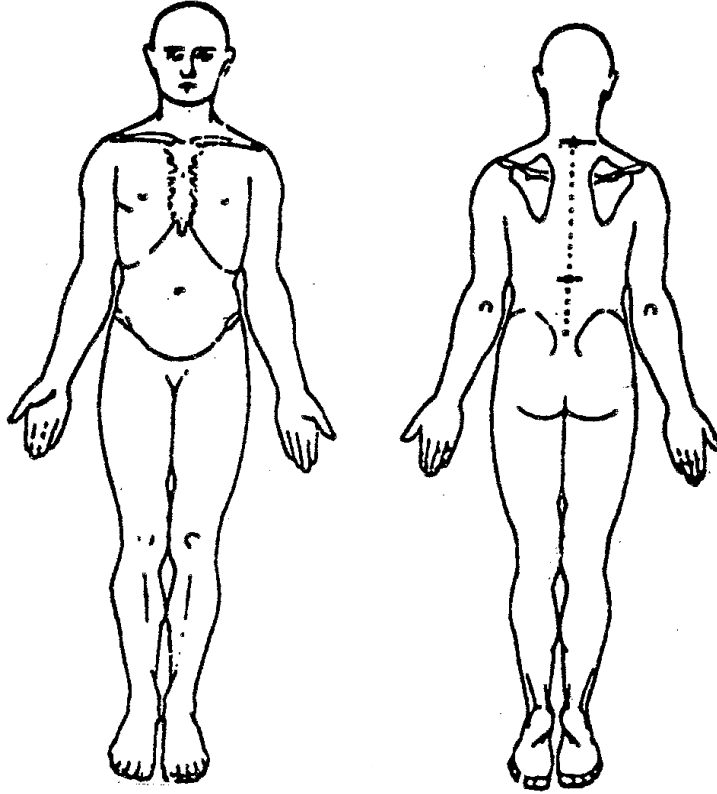
- | | |
|--|--|
| <input type="checkbox"/> Dressing self | <input type="checkbox"/> Driving a car |
| <input type="checkbox"/> Bathing self | <input type="checkbox"/> Sitting less than 15 minutes |
| <input type="checkbox"/> Preparing meals | <input type="checkbox"/> Sitting longer than 15 minutes |
| <input type="checkbox"/> Caring for children/family members | <input type="checkbox"/> Standing less than 15 minutes |
| <input type="checkbox"/> Verbally expressing self | <input type="checkbox"/> Standing longer than 15 minutes |
| <input type="checkbox"/> Concentrating on tasks | <input type="checkbox"/> Walking less than 1 city block |
| <input type="checkbox"/> Short-term memory | <input type="checkbox"/> Walking more than 1 city block |
| <input type="checkbox"/> Long-term memory | <input type="checkbox"/> Walking outdoors on uneven terrain |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Going up or down stairs |
| <input type="checkbox"/> Sexual intimacy | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Controlling/holding urine | <input type="checkbox"/> Playing/participating in a sports activity |
| <input type="checkbox"/> Bending to pick up or reach item on floor | <input type="checkbox"/> Job duties |
| <input type="checkbox"/> Getting in/out of bed | <input type="checkbox"/> Any other activity you normally participate in: |
| <input type="checkbox"/> Getting in/out of chair or sofa | _____ |
| <input type="checkbox"/> Getting in/out of the car | |

Patient Name _____

Date _____

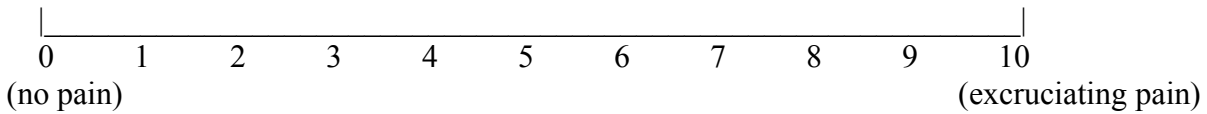
PAIN ASSESSMENT

Location of pain:

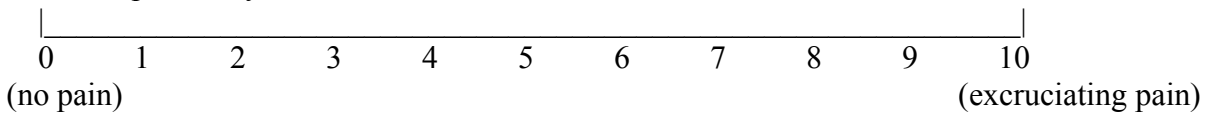


Rating of pain:

Best level in past 3 days:



Worst level in past 3 days:



Description of pain (check as many as apply):

- | | | |
|-----------------------------------|------------------------------------|--|
| <input type="checkbox"/> burning | <input type="checkbox"/> aching | <input type="checkbox"/> worst first thing in the morning |
| <input type="checkbox"/> sharp | <input type="checkbox"/> dull | <input type="checkbox"/> better first thing in the morning |
| <input type="checkbox"/> piercing | <input type="checkbox"/> throbbing | <input type="checkbox"/> worse with activity |
| <input type="checkbox"/> stinging | <input type="checkbox"/> numbing | <input type="checkbox"/> better with activity |
| <input type="checkbox"/> tingling | <input type="checkbox"/> deep | <input type="checkbox"/> awakens from sleep |

Other _____

What makes it worse? _____

What makes it better? _____

Are you taking medication for pain? NO YES – if so, what kind? _____

How much/how often? _____ Does it help? _____

Patient Name _____

Date _____