Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emerg.Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would like appt. reminders via (Circle One) TEXT E-MAIL VOICEMAIL

I give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_permission to discuss my appts., billing, and medical information with LRC.

Conditions and symptoms (check if you currently have or have had in the past)

* Anemia
* Arthritis (type & location) \_\_\_\_\_\_\_\_\_
* Asthma
* Bleeding disorders
* Bowel/Bladder dysfunction
* Cancer (location)\_\_\_\_\_\_\_\_
* Chest pain
* Depression/ anxiety
* Diabetes: Type I II (circle)
* Emphysema
* Epilepsy / Seizures
* Fibromyalgia
* Headaches
* Heart Disease
* High Blood Pressure
* History of falls
* HIV/ Hepatitis C
* Irritable Bowel Syndrome
* Insomnia
* Irregular or rapid Heart Rate
* Pacemaker
* Pelvic Pain
* Problems with cognition/thinking
* Pregnant: Y N (circle)
* Smoker
* Stroke/ TIA
* Thyroid Disease
* Tuberculosis
* Ulcers
* Unexplained weight change
* Osteoporosis
* **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
    
  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please circle if you are experiencing any of the below symptoms:

Cough Fever/ Chills Nausea/ vomiting Drop Attacks

Chest pain Trouble breathing Visual changes Dizziness

Previous Surgeries/ injuries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are we seeing you for today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Rate your pain by circling a number from 0-10 (0 is no pain, 10 is unbearable, emergency room pain)

A. At its **worst,** your pain level in the last 3 days was:

0 1 2 3 4 5 6 7 8 9 10

B. **At this moment**, your pain level is:

0 1 2 3 4 5 6 7 8 9 10

C. At its **best**, your pain level in the last 3 days was:

0 1 2 3 4 5 6 7 8 9 10

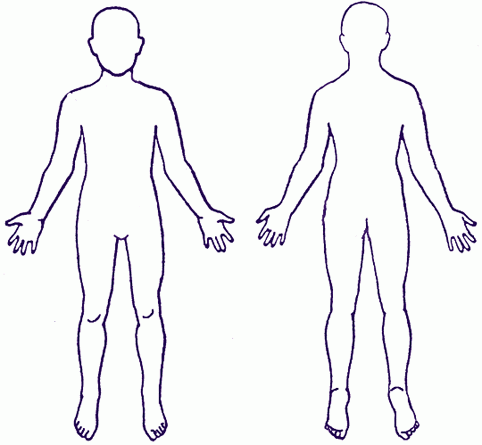
2. Circle the quality of your pain: Burning Sharp Dull/ Achy Throbbing Shooting Numbness/ Tingling (circle all that apply)

3. Is your pain: Constant Intermittent (circle one)

3. What makes your pain feel better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. What makes your pain feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Place an “X” where you are experiencing the most pain:



Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Health (How would you describe your health?):

* Poor
* Fair
* Good
* Excellent

Mental and Personal Health (Check all that apply):

* Stress is a major problem for you
* During the past month, you have been bothered by feeling down, depressed, or hopeless
* During the past month, you have been bothered by little interest or pleasure in doing things
* Problems with eating or with your appetite
* Trouble sleeping
* Current psych therapy

Regular Exercise:

* Sedentary
* Mild Exercise
* Occasional vigorous exercise (< 3x a week for 30 minutes)
* Regular vigorous exercise (> 3x a week for 30 minutes)

Work Information:

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is/are your goal(s) for therapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your interests/hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Authorization for Release of Information   * I agree that LEADBETTER REHABILITATION CLINIC may provide information from my medical record to persons directly involved in my medical care via mail, text, secure fax or email. * I authorize the release of medical information necessary to obtain payment of any benefits available to me to LEADBETTER REHABILITATION CLINIC for services rendered. * I agree that LEADBETTER REHABILITATION CLINIC may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed only in order to treat, bill, and/or receive payment. * I have been given a copy of Leadbetter Rehabilitation Clinic’s “Notice of Privacy Practices” as mandated by HIPAA. |
| Authorization for Release of Payment   * I authorize LEADBETTER REHABILITATION CLINIC to bill my insurance carrier for services rendered on my behalf * I authorize that direct payment of any benefits available to me be released to LEADBETTER REHABILITATION CLINIC for services rendered. |
| Patient Agreement   * I agree to pay LEADBETTER REHABILITATION CLINIC charges for services rendered to me during my course of treatment. * I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefits. If I fail to pay for charges that are my responsibility, I agree to pay LEADBETTER REHABILITATION CLINIC any costs associated with collecting these charges, including, but not limited to: collection agency costs, attorney and court fees.   Orthosis Fabrication/ Walk- In Splints   * I agree to pay LEADBETTER REHABILITATION CLINIC the charges not paid by my health insurance and are my responsibility per my insurance for any Orthosis/Splints that I receive. |
| Medicare, Medicaid, and Similar Benefits   * I agree that the information given to LEADBETTER REHABILITATION CLINIC in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that LEADBETTER REHABILITATION CLINIC may give Social Security Administration or its fiscal intermediaries information necessary to process claims. |
| Workers Compensation   * I agree that the information given to LEADBETTER REHABILITATION CLINIC in applying for benefits under Workers Compensation is complete and accurate. I agree that LEADBETTER REHABILITATION CLINIC may give intermediaries information necessary, including private health information, to process claims. I understand that if my Workers Compensation benefits are denied, that I am responsible for the payment of the charges from services rendered. I understand that it is my responsibility to provide LEADBETTER REHABILITATION CLINIC with accurate information regarding other insurance coverage. |

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Printed Patient Name DOB

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Patient Signature /Legal Representative/Guarantor  Date