FIRST REHAB AND SPORT
PHYSICAL THERAPY

Patient Name_____ **Date of Birth** _____

ADDRESS:_____ **CITY:** _____**ZIP:** _____

HOME phone: _____ **CELL phone:**_____
Are you interested in receiving text reminders for appointments? YES / NO

Email Address _____

Emergency Contact _____**Relationship**_____**Phone**_____

How did you learn of First Rehab & Sport?
____Previous Patient ____Friend ____Physician ____Newspaper

____Facebook ____Building Sign ____Yellow Pages ____Website

INSURANCE INFORMATION

Insured Name:_____ **Insured DOB:** _____

Primary Insurance Company_____ **Member ID:** _____

Secondary Insurance Company _____ **Member ID:**_____

Authorization to Treat, Release Information for Medical Benefits.
I hereby consent to receive medical treatment, specifically physical therapy services, at First Rehab & Sport of Middleville, MI. First Rehab & Sport has my permission to request and view medical information from other health care providers if it is directly relevant to my physical therapy treatment. This information may include, but is not limited to, x ray reports, MRI reports, surgical reports, injury/accident reports and other relevant medical history.

I also authorize the release of payment of medical benefits to First Rehab & Sport for services rendered. I understand that my insurance carrier may pay less than the actual billed services due to the terms of my insurance benefits and coverages. I agree that I will be responsible for payment of all services rendered on my behalf or the behalf of my dependant in accordance with my health plan coverage. My signature below demonstrates my understanding

Patient (or Guardian) Signature_____ **Date**_____

Medical History Related to Current Injury or Condition

Describe your current problem_____

Date of Onset_____ **Date of Surgery (if applicable)** _____

Results of X-Ray or MRI _____

Primary Doctor_____ **Phone** _____

Surgeon_____**Phone** _____

Are you currently receiving any other health care services (physical therapy, chiropractic, acupuncture, massage, injections, etc?)

_____

How is your current condition most affecting your function? (Daily activities, walking, sleeping, standing, sitting, etc)

_____

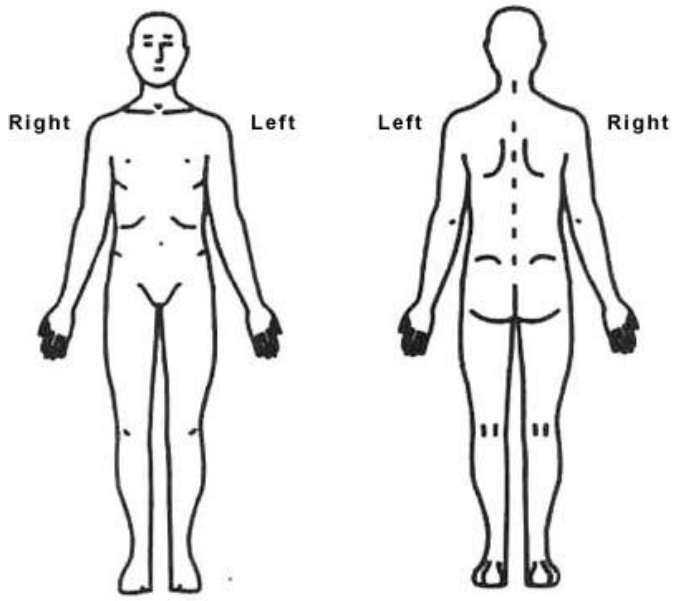
Have You Fallen in the Past 6-12 months? YES / NO IF YES, How Many Times? _____

Do you use an assistive device (cane, walker)? YES / NO
IF YES, please circle all that apply: CANE CRUTCHES WALKER WHEELCHAIR

What are your goals for physical therapy? _____

Rate CURRENT pain (0 is no pain, 10 is severe pain):_____ **Recent WORST Pain**_____

PLEASE MARK ON THE DIAGRAM WHERE YOUR PAIN OCCURS:



Circle each pain descriptor that applies

Dull Ache	**Tightness**
Constant Ache	**Burning**
Sharp	**Swelling**
Shooting	**Weakness**
Throbbing	**Tingling**
Stabbing	**Numbness**

GENERAL MEDICAL HISTORY

Please list all current medications (or provide a separate list.)

_____

_____

Please list any previous surgeries (or provide a separate list)

_____

_____

Please mark any of the following conditions of which you have a history.

Allergies	**Currently Pregnant**	**Parkinson's Disease**
Arthritis	**Epilepsy/Seizures**	**Ulcers**
Asthma	**Fibromyalgia**	**Stroke**
Blood Disorder	**Head Injury**	**Thyroid Disease**
Cancer (Type_____)	**Hearing Problems**	**Vision Problems**
High Cholesterol	**Sleep Apnea**	**Bowel Problems**
Neuropathy	**Kidney Disease**	**Bladder Problems**
Coronary Artery Disease	**Liver Disease**	**Gout**
Heart Attack	**Migraines**	**Osteoporosis**
Atrial Fibrillation	**Other Headaches**	**High Blood Pressure**
Depression	**Multiple Sclerosis**	**Allergic to Latex**
Anxiety	**Diabetes**	**OTHER: _____**
Past Pregnancies	**Pacemaker**	**OTHER: _____**