REHABAUTHORITY
Physical Therapy • Back & Neck Specialists

PATIENT MEDICAL HISTORY

Name:__________________________________ Referring Physician:________________________________

Family Physician: ________________________ Date of 1st MD visit for this injury:____________________

Is an Attorney involved in this case? YES NO

Have you had surgery for this injury? YES NO Type of Surgery: ________________Date: ________

Please list all prescription and non-prescription medication you are currently taking:

_______________________________ ____________________________ ___________________________

Please check and date any of the following Medical and/or Rehabilitative services for this Injury/Episode:

- ❏ Orthopedist ________________________________
- ❏ Neurologist________________________________
- ❏ General Practitioner ________________________
- ❏ Physical Therapist __________________________
- ❏ Podiatrist _________________________________
- ❏ Occupational Therapist ______________________
- ❏ Chiropractor ______________________________
- ❏ X-Rays ___________________________________
- ❏ MRI _____________________________________
- ❏ CT Scan __________________________________
- ❏ Emergency Room Care _____________________
- ❏ EMG / NCV ______________________________
- ❏ Myelogram _______________________________
- ❏ Massage Therapy __________________________
- ❏ Other ____

Do you now have or have you ever had any of the following:

- ❏ Asthma, Bronchitis, or Emphysema
- ❏ Shortness of Breath
- ❏ Chest Pain / Angina
- ❏ Coronary Heart Disease
- ❏ Pacemaker
- ❏ High Blood Pressure
- ❏ Heart Attack or Heart Surgery
- ❏ CVA (Stroke) / TIA (Mini Stroke)
- ❏ Blood Clot / Emboli
- ❏ Epilepsy / Seizures
- ❏ Thyroid Dysfunction / Goiter
- ❏ Anemia
- ❏ Infectious Diseases
- ❏ Diabetes
- ❏ Cancer / Chemotherapy / Radiation
- ❏ Arthritis / Swollen Joints
- ❏ Osteoporosis
- ❏ Gout
- ❏ Sleep Disorders
- ❏ Emotional / Psychological Problems
- ❏ Bowel and/or Bladder Dysfunction
- ❏ Severe or Frequent Headaches
- ❏ Vision or Hearing Difficulties
- ❏ Dizziness or Fainting
- ❏ Numbness or Tingling
- ❏ Weakness
- ❏ Unexplained Weight or Energy Loss
- ❏ Hernia
- ❏ Varicose Veins
- ❏ Allergies
- ❏ Any Pins or Metal Implants
- ❏ Joint replacement
- ❏ Neck Injury / Surgery
- ❏ Shoulder Injury / Surgery
- ❏ Elbow / Hand Injury / Surgery
- ❏ Back Injury / Surgery
- ❏ Knee Injury / Surgery
- ❏ Leg / Ankle / Foot Injury/ Surgery
- ❏ Are you Pregnant?
- ❏ Do you Smoke?

Please provide us with any other information that would assist us in your care: ______________________

What are your expectations while in this program? ____

Patient / Guardian Signature: ____Date: ________

For Official Use Only

BP:____________ HR:___________ RR:____________ HT:____________ WT:____________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

A. I have received a copy of RehabAuthority's Notice of Privacy Practices. YES NO Initial ________

B. I agree to the open treatment area used by RehabAuthority. YES NO Initial ________

C. I agree that PT/PTA students may participate in my physical therapy care. YES NO Initial ________

D. I agree that a private treatment area is not necessary. YES NO Initial ________

E. I agree that, due to this open format, unauthorized individuals may have the opportunity to learn of my protected health information. YES NO Initial ________

F. I agree that I must sign a sign-in sheet at each visit and I understand that subsequent visitors have the opportunity to read my name. YES NO Initial ________

G. I authorize RehabAuthority to send me Newsletters by mail or E-Mail with RehabAuthority News and updates as well as health news and updates. YES NO Initial ________

H. I authorize RehabAuthority and its employees to call me at my home with regards to my health status YES NO Initial ________

______________________ ______________________ ____________
Signature Please Print Name Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communications barriers prohibited obtaining the acknowledgement
____ Emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify) ______________________________

______________________ ______________________ ____________
Signature Authorized RehabAuthority Representative Please Print Name Date