Please fill this out as completely as possible so we know your health status.

Name: ______________________ Date: ____________

Height: ________ Weight: ________ Dominant Hand: ☐ R ☐ L

Pain location and description: ______________________

When did it start? ____ / ____ / ____ **Pain Scale:** No pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

Was this a result of an injury? ☐ **Yes** ☐ **No** **Work injury?** ☐ **Yes** ☐ **No** **Gradual Onset?** ☐ **Yes** ☐ **No**

Test and Results (X-Rays, MRI's, CT scans, Nerve conduction tests, etc) ______________________

Medical History: Have you had any of the following? (Check Yes or No)

☐ Yes ☐ No Allergies	☐ Yes ☐ No Coronary Artery Disease	☐ Yes ☐ No Kidney Problems
☐ Yes ☐ No Anemia	☐ Yes ☐ No Diabetes	☐ Yes ☐ No HIV/AIDS
☐ Yes ☐ No Angina	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Hepatitis A, B, C
☐ Yes ☐ No Osteoarthritis	☐ Yes ☐ No Fever (rheumatic/scarlet)	☐ Yes ☐ No Lung Disease
☐ Yes ☐ No Rheumatoid Arthritis	☐ Yes ☐ No Fever (recent)	☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Bronchitis	☐ Yes ☐ No Congestive Heart Failure	☐ Yes ☐ No Seizures
☐ Yes ☐ No Cancer	☐ Yes ☐ No Heart Attack	☐ Yes ☐ No Stroke/TIA
☐ Yes ☐ No Circulatory Problems	☐ Yes ☐ No Gout	☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Pacemaker	☐ Yes ☐ No Lupus	☐ Yes ☐ No Multiple Sclerosis
☐ Yes ☐ No Parkinson's Disease	☐ Yes ☐ No Thyroid Problems	☐ Yes ☐ No Shingles
☐ Yes ☐ No MVA with injury	☐ Yes ☐ No Bowel Incontinence	☐ Yes ☐ No Urinary Incontinence

Do you currently have or have had any other serious illnesses, mental health issues or chronic problems?

(If so, please explain) ______________________

____

Do you have any of the following: Numbness or tingling ☐ Yes ☐ No Dizziness ☐ Yes ☐ No

Visual impairments ☐ Yes ☐ No Difficulty Hearing ☐ Yes ☐ No

Are you currently pregnant ☐ Yes ☐ No If yes, how many weeks? ________

Do you smoke? ☐ Yes ☐ No Quit (year) ________

Do you exercise regularly? ☐ Yes ☐ No If yes, how often? ________

Have you had an unexplained weight loss in the last 6 months? ☐ Yes ☐ No

Surgical History: Please list all relevant surgical procedures.

____

____

____

Allergies: Please list all known allergies (food, medications, lotions, latex, etc.):

____

Medications: List all current medications, including over-the-counter medications that you are taking:

Name: ______________ Purpose: ______________

Name: ______________ Purpose: ______________

Name: ______________ Purpose: ______________

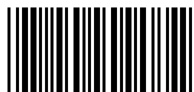
What is your goal for physical or speech therapy? ______________________

Have you received physical or speech therapy in the last 12 months? If yes, where and when? ______________

The above information is accurate and to the best of my knowledge, represents my present health. I understand the information is confidential and is provided for my safety as a participant of the HealthONE Rose Medical Center.

Signature ______________________ Date ____________ Time ____________

Patient Information/Label

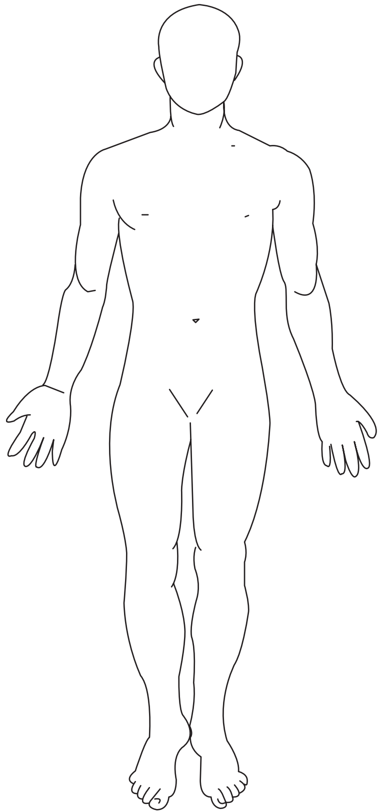


Medical History

NNS
89816 (01/12)

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, draw in your face.

Front



Numbness
|| || || ||

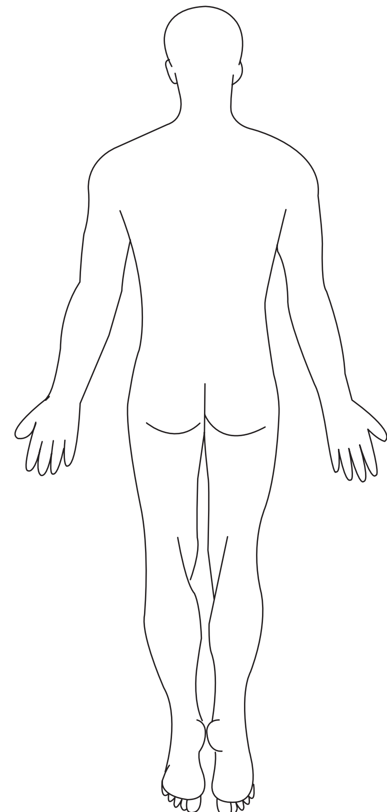
Pins and Needles
0 0 0 0 0

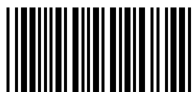
Burning
XXXXX

Stabbing
//////

Ache
^^^^

Back





Medical History

Patient Information/Label

NNS
89816 (01/12)

Welcome to Rose Medical Center Sports Medicine and Rehabilitation! You are very important to us, and we have reserved this appointment especially for you. In order for you to obtain optimal benefits from your treatment program, it is essential that you attend each and every scheduled visit and follow a few simple guidelines. Your first appointment will last 30-60 minutes; follow-up visits last 30-45 minutes. Please arrive 20-30 minutes before your first scheduled appointment time to complete the required paperwork.

We are here as part of your rehabilitation team to teach you to manage your injury or condition. Our policies exist to promote continuity of care and recovery progress and to reduce the length of disability.

ALCOHOL Alcohol and non-prescribed substances are not allowed on the premises. If you have been drinking alcohol or are using non-prescription drugs before your treatment, you will not be allowed to participate in therapy.

ATTIRE Comfortable, loose fitting clothes (such as shorts, T-shirts, and sweats) should be worn with comfortable shoes.

VISITORS Because of space limitation and for safety reasons, children and other family members or friends are not allowed in the treatment areas. Children left in the waiting area MUST be accompanied by an adult. Our staff cannot supervise children left in the waiting area.

INSURANCE We are happy to verify your insurance coverage prior to your treatment; however, it remains the patient's responsibility to know which services your insurance covers.

Initial: __________

ATTENDANCE

1. All cancellations should be made as soon as possible in advance of the scheduled appointments, preferably no less than 24 hours prior to the appointment.

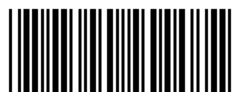
2. If you fail to attend a scheduled appointment (and did not call to cancel or reschedule), you will be considered a "no-show". Reasonable attempts will be made to accommodate you based on availability, however, this cannot be guaranteed.

   Initial: __________

3. If you "no-show" for <u>two</u> therapy sessions or have <u>a total of three cancelled therapy appointments</u>, we reserve the right to discharge you from therapy. A phone call of formal letter will be sent to your physician, case manager and/or your employer/insurance carrier, and no further appointments will be scheduled without a new referral from your physician.

4. The frequency of your appointments is determined by your physician and therapist based on your injury or condition, but is usually 2-3 times per week. Appointments should be scheduled at least one week in advance.

5. It is your responsibility to reschedule a missed appointment and you are encouraged to do this as soon as possible.



Welcome

Patient Information/Label

Workman's Compensation Patients:

If you are a worker's compensation patient and fail to attend a scheduled appointment, your Employer and adjuster will be notified that you did not attend your scheduled therapy visit. "No-shows" and cancellations may affect your worker's compensation benefits.

It is your responsibility as a worker's compensation patient to know your employer's policy regarding therapy appointment times. If you are working (even part-time or on restricted duty) your employer may require your therapy visits be scheduled during non-working hours. Make sure that you advise your therapist of your employer's scheduling requirements.

All Patients:

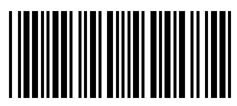
Please notify your therapist if you are pregnant, have a pacemaker, wear a hearing aide, or suffer from any serious medical condition/illness.

Also, please notify your therapist if you experience any change in your medical history during your course of therapy.

I have read and understand the above information. I agree to follow these guidelines while participating in therapy and am aware this document will be filed in my medical chart.

Patient Signature	Date	Time

Patient Information/Label



Welcome

PINS
89818 (10/11)

Your provider will, at times, need to contact you.

By filling out the information below, we will be able to better serve you.

Phone Message Consent

In an effort to protect your privacy, we have developed a policy on leaving medical care messages:

- **We will NOT leave a message with anyone except the patient or legal guardian.**
- **We will NOT leave any confidential information on an answering machine.**
- **We will NOT leave any messages on a voicemail.**

UNLESS

WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I, ______________________________, give HealthONE my permission to speak with and/or leave phone messages regarding my medical care and/or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

Home Phone Number ______________________________ Initials ______________

Work Phone Number ______________________________ Initials ______________

Cellular Phone Number ______________________________ Initials ______________

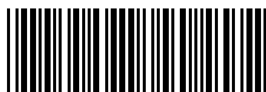
Spouse/Guardian ______________________________ Initials ______________

Name: ______________________________

Other ______________________________ Initials ______________

Name: ______________________________

Signature: ______________________________ Date: __________ Time: __________



How Can We Reach You?

Patient Information/Label

ADMIN
89817 (01/12)

POINT OF ENTRY SCREENING

Name: ____ Date: _________________________

Is the patient currently experiencing or has patient experienced in the past 7 days, any of the following:

	Yes (Y)	No (N)
Fever greater than 100.4?		
Cough?		
Cough greater than 3 weeks?		
Cough with blood produced?		
Sore throat?		
Night sweat?		
Unexplained weight loss?		
Fatigue?		
Body aches?		
Rash?		
Nasal congestion not having to do with allergies or sinus infection?		
Prior history of TB or positive TB skin test?		
Close contact with a person who has TB?		
Close contact with a person having an Influenza-like illness?		
Traveled outside the USA in the past 2 weeks? Yes - Name of Country _________________________		
Have you recently been exposed to a person or an environment that may have had bed bugs?		

REV. 6/2015