PATIENT INTAKE PROFILE

DATE____________ NAME_________________________________ AGE_______ SEX_______

HISTORY

1. Have you had previous physical therapy visits **this year**? **YES** **NO** If **YES**, how many? ______

   Have you received Chiropractic service visits **this year**? **YES** **NO** If **YES**, how many? ______

2. What is your chief complaint? ____

3. How did this problem begin? ____

4. When did this problem begin? ____

   If this began more than 6 weeks ago, what prompted you to see the doctor now? _____________

   ____

5. Have you ever had a similar problem before? **YES** **NO** If yes, please explain_______

   ____

6. Have you ever had any of the following conditions? (Please circle): Asthma Emphysema

   Cancer High Blood Pressure Arthritis Heart Problems Diabetes

7. Do you smoke? **YES** **NO**

8. Do you get dizziness/spinning sensation with position changes **YES** **NO**

9. Do you have a fear of falling that restricts activity? **YES** **NO**

10. Do you feel unsteady when walking or standing? **YES** **NO**

11. Have you fallen in the last year? **YES** **NO** If **YES**, how many times? ______

PREVIOUS TREATMENT

12. List all surgeries you have undergone.

    ___________________________________ Date_____________

    ___________________________________ Date_____________

    ___________________________________ Date_____________

13. What tests have you had done for this condition? (Please circle all that apply)

    X Rays EMG MRI CT Scan Lab Tests

    OTHER:_______________________________________

ACTIVITY TOLERANCE

14. What 3 functional activities are you unable to perform or have the most difficulty performing?

Patient Specific Functional Activity (0=unable to perform, 10=no difficulty)	**0** ☹	**1**	**2**	**3**	**4**	**5** 😐	**6**	**7**	**8**	**9**	**10** ☺
1.											
2.											
3.											

15. Please list your hobbies and/or interests ____

____

SYMPTOM INFORMATION

16. What symptoms are you having? (Please circle all that apply): Aching Burning Catching Clicking Cramps Giving Out Grating Heaviness Locking Numbness Pinching Popping Pounding Sharp Sore Spasms Stiffness Stinging Swelling Tender Tingling Throbbing Weakness Other:______________________________

If you are having **pain**, circle one number in each row that represents your pain level.											
0 is no pain and 10 requires hospitalization	☺					😐					☹
Typically, my pain is about a…	0	1	2	3	4	5	6	7	8	9	10
At best, my pain is about a…	0	1	2	3	4	5	6	7	8	9	10
At worst, my pain is about a…	0	1	2	3	4	5	6	7	8	9	10

What % of the time are you in pain:	I do not have pain	1-20%	21-40%	41-60%	61-80%	81-100%

17. List all allergies to food, medication, other substances ______________________________

____

18. Is any litigation or insurance settlement regarding your pain/accident/injury pending?

YES NO

19. What is your primary goal for treatment? ____

____

ADDITIONAL INFORMATION

How did you come to know of our facility? (Please check all that apply)

____ Your doctor referred you to us.

____ A friend/relative referred you to us.

____ You were a previous patient here.

____ Location/saw our sign from the road

____ Advertising/website

____ Insurance Company

____ Other: ____

Emergency Contact

Name: ______________________________

Relationship: _________________________

Phone: ______________________________

Can we have your e-mail address for patient portal access? ______________________________

Thank you. This information is very valuable to us.

______________________________ ______________________________

Patient Signature **Therapist Signature**

Specialists In Rehabilitation Medicine, P.C.

Physical Medicine • Rehabilitation
Sports Medicine • Carpal Tunnel
Electromyography • Back Pain
Acute Pain Management
Occupational Medicine
Interventional Pain Medicine

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AUTHORIZATION TO TREAT & ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO:

SPECIALISTS IN REHABILITATION MEDICINE, P.C.

Patient____

I HEREBY AUTHORIZE SPECIALISTS IN REHABILITATION MEDICINE, P.C., TO PROVIDE PHYSICAL THERAPY TREATMENT AS INDICATED BY MY PHYSICIAN.

I hereby instruct and direct______________________________ Insurance Company to pay any of my charges by a check payable to Specialists in Rehabilitation Medicine, P.C., and mailed directly to 1135 W University Dr. STE 425 Rochester, MI 48307.

If my current policy prohibits direct payment to the above company, then I request and instruct the above insurance company to send any check made payable to me for these charges to be sent to Specialists in Rehabilitation Medicine, P.C., 1135 W University Dr. STE 425 Rochester, MI 48307.

I understand that this is a direct agreement of benefits or rights I have or may have under my insurance policy. A copy of this agreement shall be as valid as the original. I hereby authorize Specialists in Rehabilitation Medicine, P.C., to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, insurance companies, adjuster or attorney involved in the case.

I understand that my insurance company may not pay any or all of the costs of services rendered to me by Specialists in Rehabilitation Medicine, P.C. I agree to be personally responsible for the payment in full of any bills from or debts owed to Specialists in Rehabilitation Medicine, P.C., for services or treatment rendered to me or on my behalf. In the event Specialists in Rehabilitation Medicine, P.C. is not properly paid, then I agree that a service charge of $25 may be added to the amount owed after such amount is over 31 days old. I further agree that if Specialists in Rehabilitation Medicine, P.C., files suit to attempt to collect any amounts owed, then I agree that their attorney's fees and costs shall be added to the amount owed and/or any judgment in addition to the service charge outlined above.

____
Patient Signature   Date

____
Witness Signature   Date