



Physicians Rehabilitation

952 S State Route 2, Valparaiso, IN 46352 :: 219-757-3884
9010 Connecticut Street, Merrillville, IN 46410 :: 219-757-3884
3567 Village Court, Gary, IN 46408 :: 219-981-8111

PATIENT INFORMATION EMAIL ADDRESS:

Form section for Patient Information including fields for First Name, Last Name, Middle Initial, Date, Address, City, State, Zip, Birth date, Age, Gender, S.S. #, Home Phone, Alternative Phone, Spouse, and reasons for clinic choice.

WORK INFORMATION

Form section for Work Information including fields for Employer, Work Phone, Ext., Occupation, and Employment Status.

CARE PROVIDER INFORMATION

Form section for Care Provider Information including fields for Referring Dr., Referring Dr. Phone, Regular Dr./PCP, and Regular Dr./PCP Phone.

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Form section for Insurance Information including fields for Primary Insurance Name, Subscriber's Name, Birth date, ID. #, Group/Policy #, and Patient's Relationship to Subscriber.

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Form section for Auto or Work Injury Claim including fields for Insurance Name, Adjuster/Claim Manager, Phone, Address, City, State, Zip, Claim #, Accident Date, and Cause.

ATTORNEY INFORMATION

Form section for Attorney Information including fields for Name, Law Firm, Phone, Address, City, State, and Zip.

IN CASE OF EMERGENCY

Form section for In Case of Emergency including fields for Name of Local Friend or Relative, Relationship to Patient, Home Phone, and Work Phone.

I authorize my insurance benefits be paid directly to Physicians Rehabilitation. I understand that I am financially responsible for any balance. I also authorize \_\_\_\_\_ to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE

DATE

# PAST MEDICAL HISTORY FORM

Patient Name \_\_\_\_\_

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION			Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS			Other: _____		
	YES	NO	_____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			
What types of exercise do you perform? : _____				
What things cause stress in your life? : _____				

Are you taking any seizure medication?  YES  NO If yes list name: \_\_\_\_\_

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?  
 YES  NO If yes list name: \_\_\_\_\_

List all medications you are currently taking: \_\_\_\_\_

List all surgeries in the past two years (Including dates): \_\_\_\_\_

Are you pregnant?  YES  NO What week?: \_\_\_\_\_

Have you had any injuries related to work?  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had any Auto Accidents  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had Physical Therapy or Massage Therapy before?  YES  NO Where: \_\_\_\_\_

Signature of Patient, Parent, Guardian, Personal Representative

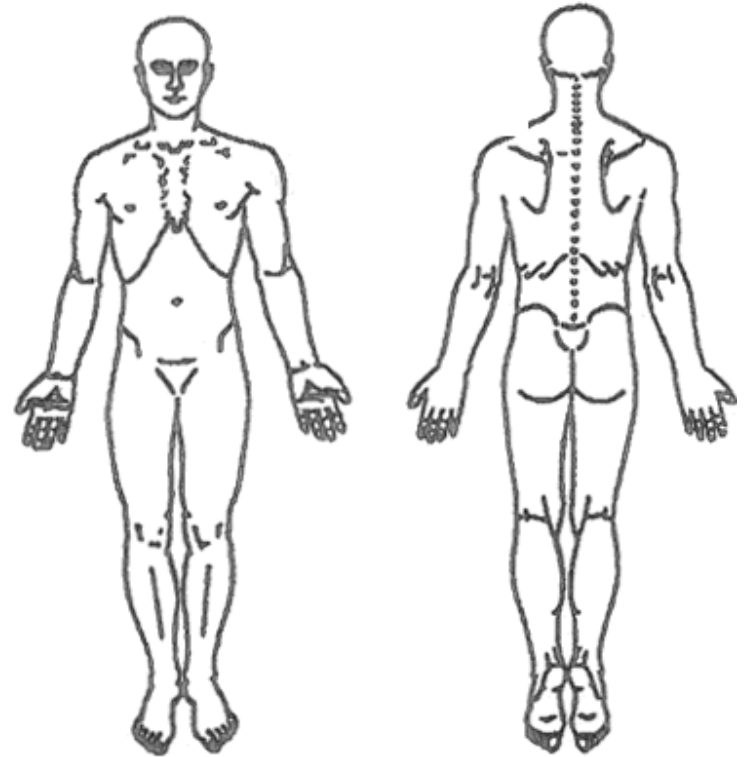
Date

# Pain and Symptom Status Report

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



- |   |                              |                                |
|---|------------------------------|--------------------------------|
| <b>Ache</b><br>MMM<br>M                         | <b>Burning</b><br>---<br>--- | <b>Numbness</b><br>OOOO<br>OOO |
| <b>Pins and Needles</b><br>□□□□□□□□<br>□□□□□□□□ | <b>Stabbing</b><br>/////     | <b>Other</b><br>xxxx<br>xxx    |

## Chief Complaint and Visual Analog Scale

My Chief Complaint is: \_\_\_\_\_

Date First Symptom of your problem occurred on: \_\_\_\_\_

2nd Complaint: \_\_\_\_\_

3rd Complaint: \_\_\_\_\_

<b>Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:</b>												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it
<b>Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:</b>												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it
<b>Please circle on the scale below to indicate your <u>WORST</u> level of pain:</b>												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it

Additional Comments \_\_\_\_\_