HANDS ON Rehabilitation, Inc.

PATIENT INFORMATION			EMAIL ADDRESS:______________________________
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Family ☐ Friend	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			
WORK INFORMATION			
Employer:		Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed		
CARE PROVIDER INFORMATION			
Referring Dr:		Referring Dr. Phone: ( ) -	
Regular Dr./PCP		Regular Dr./PCP Phone: ( ) -	
INSURANCE INFORMATION	**(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**		
Primary Insurance Name:			
Subscriber's Name (If different):			Birth date : / /
ID. #:	Group/Policy #		
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:			
Name of Secondary Insurance:			
Subscriber's Name:			Birth date : / /
ID. #:	Group/Policy #		
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:			
AUTO OR WORK INJURY CLAIM	**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**		
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:		Phone:	Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	
ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:
IN CASE OF EMERGENCY			
Name of Local Friend or Relative (Not Living at Same Address):			
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -	

I authorize my insurance benefits be paid directly to **Hands On Rehabilitation, Inc.** I understand that I am financially responsible for any balance. I also authorize **Hands On Rehabilitation, Inc.** to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

HANDS ON
Rehabilitation, Inc.

PAST MEDICAL HISTORY FORM

Patient Name ______________________________

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Cancer (presently or history of)	☐	☐

Other: ______________________________

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EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day _____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week _____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week _____
☐ 5+ x Week	☐ 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

HANDS ON
Rehabilitation, Inc.

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.

Ache	Burning	Numbness
MMMM MM	– – – – –	OOOO OOO
Pins & Needles	**Stabbing**	**Other**
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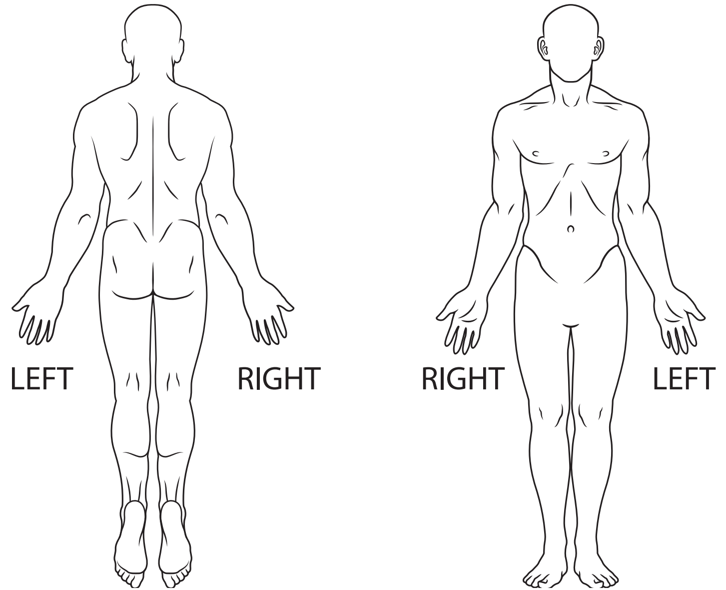

Chief Complaint and Visual Analog Scale

My Chief Complaint is: ______________________________

Date First Symptom of Your Problem Occurred on: ______________

2nd Complaint: ______________________________

3rd Complaint: ______________________________

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

Additional Comments: ______________________________

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Patient Missed Appointment Policy

Our mission at Hands on Rehabilitation, Inc. is to help you get back to whatever it is that you've been missing. We want to help you get better!

Your committment to your home program and therapy schedule is imperative for you to achieve the best results. Adhering to your therapy schedule is a vital factor to achieve the successful results we all want.

Therefore, we have a policy that needs to be followed to ensure optimum results. Except for serious emergencies, it is expected that you keep all of your appointments. If you need to reschedule, we require 24 hours notice. In such a case, please call our office (440)-460-0344 and arrange for a make-up appointment. The make-up appointment needs to be in the same week for the continuity of your care.

In the instance of cancellation without 24-hour notice or if you do not show up to a scheduled appointment, we reserve the right to charge you a $50.00 fee.

For Worker's Compensation patients, we must report your attendance and progress to your Physician and Case Manager or Third-Party Administrator. Unexcused absences can, in some cases, terminate your worker's compensation benefits.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

I hereby authorize treatment by Hands On Rehabilitation, Inc. I request that payment of authorized insurance benefits be made for any services furnished to me by them. I understand that if I do not have a necessary referral from my PCP or authorization from my insurance company, I will be held responsible for payment. Furthermore, I understand that Hands on Rehabilitation, Inc. will bill by insurance company, and I am responsible for the prompt and full payment of any co-payments, deductibles, co-insurance and supplies that may apply or are not covered by my insurance. I also authorize Hands On Rehabilitation, Inc. to release to my insurance company and it's agents, any information needed to determine these benefits or the benefits payable for related services or to facilitate the delivery of medical services. If my insurance company does not make payment, my insuranace is terminated, or I do not have insurance, I understand that I am fully responsible for any and all charges resulting from my therapy and or supplies and equipment I recieve during my therapy.

I aknowledge the above is true and correct, and additionally have read and understand the Patient Missed Appointment Policy.

Name____ Date_____________________________