Date of Eval _____ **Patient Information Form** Date Intake Taken:_____

Patient # _____

Name _____ Date of Birth_____ SS#_____-_____-_____

Address_____City_____State_____ Zip Code_____

Home Phone_____ Cell Phone_____ Sex_____ Marital Status_____

E-mail address_____

Occupation_____

Date of Accident (if WC/MVA) _____ Type of Accident: **MVA** **WC** **OTHER**

Injury Area _____ Post-OP_____

Primary Insurance_____ Insurance ID#_____

Spouse Name _____ Insurance Phone_____

***WC and MVA Patients:** Adjuster Name _____

Adjuster Phone _____ Claim Number _____

Secondary Insurance_____ Insurance ID#_____

Insurance Phone_____

Referring Doctor_____ Phone Number _____

Primary Care Physician_____

Do you have a **Rehab Nurse or Case Worker?** Name _____ Phone _____

Do you have an attorney? Name _____ Phone Number_____

Emergency Contact Name_____ Phone Number_____

How Did You Hear About Us? Friend Hospital TV Doctor Online Attorney Other _____

Have you received any outpatient physical or speech therapy in this calendar year?_____ If yes, when?_____ where?_____

Have you received any outpatient occupational therapy in this calendar year?_____ If yes, when?_____ where?_____

Patient Medical History

With whom do you live?

☐ Alone ☐ Spouse only
☐ Spouse and child(ren)
☐ Child(ren) only ☐ Other relatives
☐ Other _____

Where do you live?

☐ Private home ☐ Apartment
☐ Assisted living/ group home
☐ Other _____

Does your home have:

☐ Stairs, no railing ☐ Stairs, railing
☐ Ramps ☐ Elevator
☐ Assistive devices
_____
☐ Obstacles _____

Do you use:

☐ Cane ☐ Glasses
☐ Walker ☐ Hearing aids
☐ Wheelchair

Please circle if you have ever had:

☐ Arthritis
☐ Broken bones, fractures
☐ Osteoporosis
☐ Blood disorders
☐ Circulation/vascular disorder
☐ Heart problems
☐ Pacemaker
☐ High blood pressure
☐ Lung problems
☐ Stroke
☐ Diabetes/high blood sugar
☐ Low blood sugar/hypoglycemia
☐ Head injury
☐ Multiple sclerosis
☐ Muscular dystrophy
☐ Parkinson's disease
☐ Seizures/ epilepsy
☐ Developemental/growth disorders
☐ Thyroid problems
☐ Cancer
☐ Infectious disease
☐ Kidney problems
☐ Ulcers/ stomach problems
☐ Skin diseases
☐ Depression
☐ Other_____

Is there any chance that you are currently pregnant? ☐ Yes ☐ No

Within the past year, have you had any of the following symptoms:

☐ Chest pain
☐ Heart palpitations
☐ Shortness of Breath
☐ Dizziness or blackouts
☐ Coordination problems
☐ Weakness in arms or legs
☐ Loss of balance
☐ Difficulty walking
☐ Joint pain or swelling
☐ Pain at night
☐ Difficulty sleeping
☐ Loss of appetite
☐ Nausea/ vomiting
☐ Weight loss/ gain

☐ Other _____

Have you ever had surgery?

☐ Yes ☐ No

Surgery Date

_____
_____
_____

Do you take prescription medications?

☐ Yes ☐ No
If yes, please list _____

_____

_____

Do you take any non-prescription medication? ☐ Yes ☐ No

☐ Advil/Aleve
☐ Ibuprofen/ Naproxen
☐ Aspirin
☐ Tylenol
☐ Other _____

Patient Medical History cont.

Within the past year, have you had any of the following tests?

- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood tests
- ☐ Bone scan
- ☐ CT scan
- ☐ Doppler ultrasound
- ☐ Echocardiogram
- ☐ EMG
- ☐ EKG
- ☐ MRI
- ☐ Myelogram
- ☐ Nerve conduction velocity
- ☐ Pulmonary function test
- ☐ Stress test
- ☐ X-rays
- ☐ Other: _____

I certify that all of the information on this intake form is true and correct to the best of my knowledge and that I understand the policies of Aquahab Rehabilitation. I give my consent to receive any and all treatment that is rendered at Aquahab Rehabilitation. I am responsible for notifying the Center of any changes in my health or billing information. I give consent for the Center to bill my insurance company and for assignment of direct payment to the Center by my insurance company. The Center will make every effort to collect payment from my insurance company, however I understand that regardless of my account status, I am ultimately responsible for all charges incurred for professional services rendered at Aquahab Rehabilitation to the extent that the law allows.

Signature_____**Date**_____

I authorize the release of any all information in your possession, custody, and control, including x-rays, medical records, and emergency room records and test reports. The undersigned expressly authorizes the release of my complete hospital/physician's office chart to Aquahab Rehabilitation. I also give consent for the Center to release their records, within the guidelines of the law, as necessary to my physician, insurance company, rehab nurse/case manager or attorney.

Signature_____**Date**_____