

COPPELL SPINE & SPORTS REHAB L.P. MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____

REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____

CAUSE OF INJURY OR ONSET: _____ ARE YOU PRESENTLY WORKING? Y N

PRIMARY CARE PHYSICIAN'S NAME: _____ DATE OF NEXT MD APPT: _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR
DO YOU USE TOBACCO? (circle one) YES NO IF YES, HOW MUCH? _____

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN _____ AND WHY _____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE / WHAT WERE THE RESULTS: _____

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: _____

ALLERGIES: Medication _____ Reaction _____ Medication _____ Reaction _____

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction _____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction _____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> ASTHMA <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> COPD <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> CARDIOVASCULAR PROBLEMS | <input type="checkbox"/> FRACTURES | <input type="checkbox"/> Other |
| <input type="checkbox"/> HOLTER MONITOR - currently wearing? | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SEIZURES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> HEPATITIS/HIV | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> KIDNEY PROBLEMS | |
| <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> MRSA (Methicillin Resistant Staphylococcus Aureus) | |
| <input type="checkbox"/> CURRENTLY PREGNANT | <input type="checkbox"/> OSTEOPOROSIS | |

If checked any above, explain: _____

ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____ Date _____

PATIENT INTAKE AND CONSENT FORM

Please Initial Each as Applicable:

Internal Use Only: A/C# Name A/C Type Office#

CONSENT TO TREATMENT: I consent to rehabilitation and related services at ... In so doing, I understand, acknowledge and affirm that such rehabilitation and ... involve bodily contact, touching and/or direct contact of sensitive nature.

TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

LIABILITY: I know and agree that ... is not responsible for loss or ... personal valuables.

WAIVER AND RELEASE: I hereby release, discharge and acquit ... representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment.

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices.

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Witness Signature _____

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of ... This form must be completed in its entirety and provided to ... prior to initiation of therapy services.