DIVERSIFIED
Rehabilitation Services

Physical Therapy and Occupational Therapy Intake Forms

First Name: _______________________ Middle Name: ______________ Last Name: ___________________________

Address:____ Apt/Unit:________________

City:____ State:___________ Zip::______________________________

Date of Birth: ____/____/_______ Gender: _____________ Last 4 of Social Security #: ____ ____ ____

Home Phone #: _________________ Cell #: _________________E-Mail: ___________________________________

Emergency Contact: ______________________________ Phone#:________________ Relationship:______________

Primary Doctor:____ Phone #: __________________________________

Referring Doctor:____ Phone #: __________________________________

Do you have a follow-up scheduled at your referring physician? ___Y ___N If yes, when:_________________________

Do you live in a Skilled Nursing or Assisted Living Facility, or Rehab Center? Y _ N_ name/phone:__________________

Consent for Treatment

The patient/legal guardian authorizes Diversified Rehabilitation staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Consent to Release Medical Information

I authorize Diversified Rehabilitation Services to release any information acquired in connection with my diagnostic/treatment services including, but not limited to, diagnosis & clinical records, to myself, my insurance(s), physician(s), and ___________________

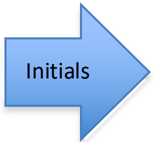
Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Diversified Rehabilitation Services.

Primary Insurance Name ______________________ ID # ________________ Group # ________________

Primary Insurance Card Holder Name __________________ Primary Card Holder Date of Birth ___ / ___ / ___

Secondary Insurance Name ____________________ ID # ________________ Group # ________________



Guarantee of Payment: I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when a patient does not call to cancel an appointment, he/she is preventing another patient from getting much needed assistance. Out of this necessity, if an appointment is not cancelled by 4 PM the day preceding the scheduled appointment, a twenty-five dollar ($25) fee will be charged; this will not be covered by your insurance company. Thank you for understanding

I hereby certify that I understand these rights as set forth

I acknowledge that I have been informed of Diversified's Privacy Practices as required by the Health Insurance Portability And Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information. A current copy of our Privacy Practices is available to you upon request. I further understand that I am concenting to receive emails and/or voice message unless otherwise stated.

Client/Responsible Party Signature: ______________________________________Date:____________________

Legal Representation (If applicable): Name:___________________________ Signature:_____________________

DIVERSIFIED Rehabilitation Services

Patient Name: ________________________________

Date: _____________

Past Medical History

Do you have, or have you had, any of the following?

Neurologic

- ☐ Migraine
- ☐ Stroke/TIA
  - If so, when? ___________________________
- ☐ Parkinson's Disease
- ☐ Seizures/ Epilepsy
- ☐ Concussion/Head Injury
  - If so, when? ___________________________
- ☐ Multiple Sclerosis
- ☐ Alzheimer's
- ☐ Other Neurologic ________________________

Cardiovascular

- ☐ Heart Attack
  - If so, when? ___________________________
- ☐ Pacemaker
- ☐ Peripheral Arterial Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Other Cardiovascular______________________

Respiratory

- ☐ Breathing Difficulties
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Other Respiratory _______________________

Other Health Issues:

____

____

____

____

Orthopedic

- ☐ Artificial Joints
  - If yes, which?_________________________
- ☐ Arthritis
- ☐ Back Problems
- ☐ Back Surgery
  - If so, when? __________________________
- ☐ Neck Problems
- ☐ Osteoporosis/Osteopenia
- ☐ Other Orthopedic______________________

Vision

- ☐ Cataracts
  - If removed, when?______________________
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other Vision __________________________

Other

- ☐ Cancer
  - Type: _____________________________
- ☐ Diabetes
- ☐ Neuropathy
- ☐ Depression
- ☐ Anxiety
- ☐ Thyroid
- ☐ Gastrointestinal Problems
- ☐ Rheumatoid Arthritis
- ☐ Tobacco Use
  - If yes, how much?_____________________
- ☐ Alcohol Use
  - If yes, how much?_____________________

Continue to next page

Patient Name: ___________________________________

Date: ______________

Prescription	Dosage	Frequency	Route	Reason

Please list all of your **current medications and supplement**

Over the counter	Dosage	Frequency	Route	Reason

Supplements & Vitamins	Dosage	Frequency	Route	Reason

Medical intake form:(Orthopedics): Physical Therapy/Occupational Therapy Today's Date:________________

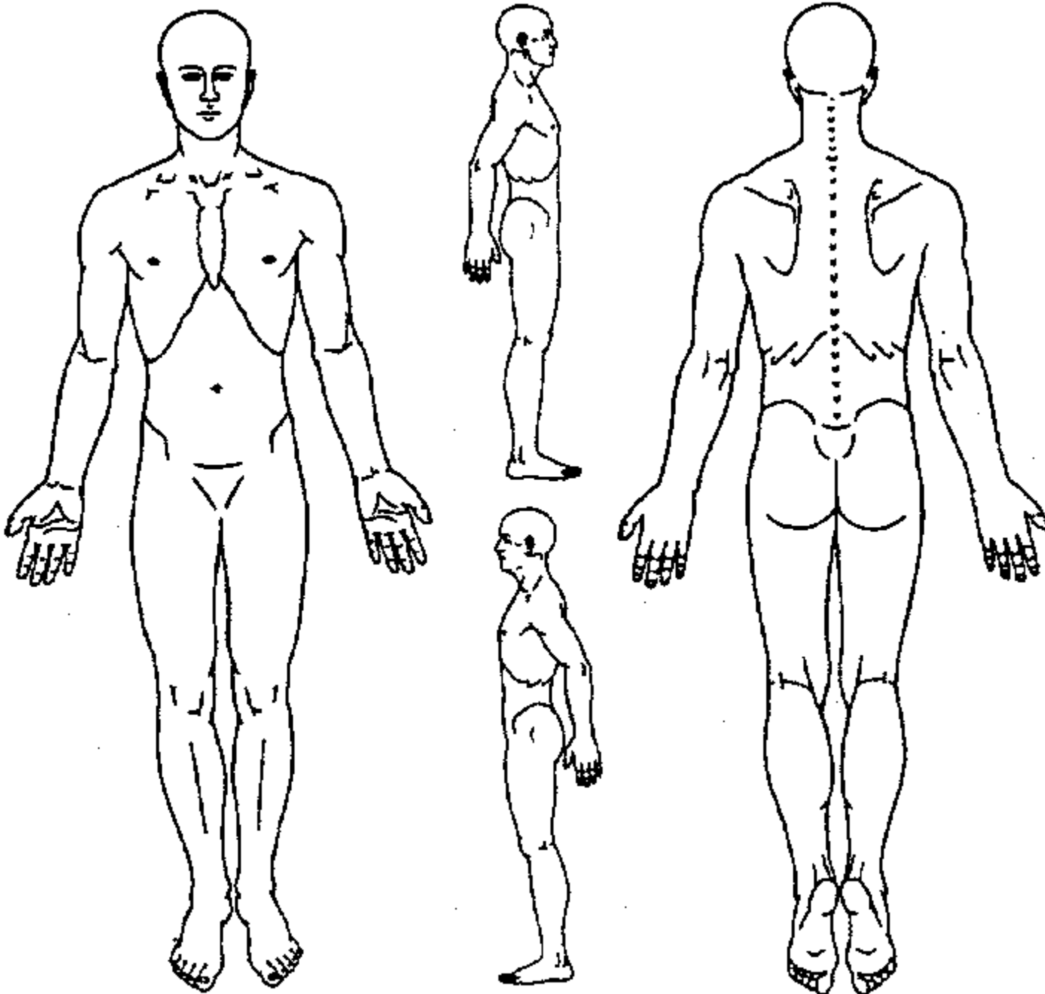
Name: ____ Date of Birth: _______________ Age: ______

In your own words, please state your problem:____

____

____

Pain Diagram: Shade in these drawings according to where you hurt *RIGHT NOW or where you feel your symptoms* (IE: If the left side of your neck hurts, shade in the drawing on the left side of your neck.



Name: ____ Date:________________

Pain scale : On the scale below, circle the number which best represents the average level of pain you have experienced over the last 48 hours:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Are you presently taking any medications for pain? ( ) Yes ( ) No If yes, please list on Medications form.

Past Medical History: Please check (X) if you have been treated for:

( ) Heart Problems
( ) Dizziness or Fainting
( ) Shortness of Breath
( ) Calf pain with exercise
( ) Severe headaches
( ) Recent accident
( ) Head trauma/concussion
( ) Muscular weakness
( ) Cancer
( ) Joint dislocation
( ) Broken bones
( ) Unexplained weight loss
( ) Frequent Falls
( ) Tremors
( ) High blood pressure (Hypertension)
( ) A wound that doesn't heal
( ) Kidney or Liver disease
( ) Blurred vision
( ) Lung Disease/Problems
( ) Arthritis
( ) Swollen and/or painful joints
( ) Irregular heart beat
( ) Stomach pains or ulcers
( ) Pain with cough or sneeze
( ) Back or neck injury
( ) Diabetes
( ) Stroke
( ) Balance problems
( ) Muscular pain with activity
( ) Epilepsy/seizures/convulsions
( ) Chest pain or pressure at rest
( ) Allergies (latex, medications, food)
( ) Constant pain unrelieved by rest
( ) Night pain (while sleeping)

Function: On a scale of 0 to 10 being able to perform all of your normal daily activities, and 10 being no problem in performing any of your normal daily activities, give yourself a score for your current ability to perform your activities of daily living. _______________

Current History:

What date (approximately) did your present symptoms start? ___________________________________

How? (gradually, suddenly, injury) ____

How have your symptoms changed? ( ) getting better ( ) about the same ( ) getting worse

What makes your symptoms better? ____

____

What makes your symptoms worse? ____

____

Name: ____ Date:_________________

Have you had an x-ray, MRI, or other testing for this problem? No / Yes (specify)

____

____

What treatments have you received for this problem so far?

____

____

Have you recently had an x-ray, MRI, or CT scan for your condition or other testing for this problem?
( ) Yes ( ) No Specify____

____

Please mention any addition problems or symptoms you feel is important, Including your goal for therapy: ____

<u>Do you have problems with?</u>

( ) Speaking ( ) Eating ( ) Swallowing ( ) Remembering. ( ) Walking ( ) Strength. ( ) Pain

( ) Hand Dexterity ( ) Hearing ( ) Falling ( ) Balance. ( ) Numbness/Tingling. ( ) Headaches

( ) Dizziness. ( ) Depression ( ) Dressing ( ) Washing/Bathing ( ) Grooming

<u>Aggravating Factors</u>: Identify up to 3 important activities that you are unable to do or have difficulty with as a result of your problem.

1) ____
2) ____
3) ____

During the past 3 months, have you seen any medical professional (doctor, chiropractor, PT,

osteopath, etc)? Yes / No If yes, please describe the reason. ______________________________________