Quality Rehab Solutions

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To Our Valued Patient:

Welcome to Quality Rehab Solutions. We are committed to assisting you in reaching your rehabilitation goals. In order to achieve your goals, it is important that you attend your scheduled appointments. Missed appointments can delay your progress and recovery. Also, arriving late for your appointments can result in a limited treatment session or altogether cancellation of that appointment.

We understand that emergencies, illnesses, and unforeseen scheduling conflicts occur. However, our clinic policy requires that you contact the clinic at least 24 hours prior to your visit if you need to cancel or change your scheduled appointment (inclement weather excluded). This allows us to offer the time to other waiting patients. Physical therapy may be discontinued after a combination of 2 no shows or short notice cancellations.

I have read, understand, and agree to the information listed above.

Patient signature: ______________________________ Date: ____________

Medical History

A complete medical history is necessary for a thorough evaluation. Please answer the following questions:

Your Name:				Date:
Date of Birth:	Age	Height	Weight	Do you smoke? No Yes

Have you ever been diagnosed with any of the following?

Tuberculosis	No	Yes	Congestive Heart Failure	No	Yes
Hepatitis	No	Yes	High Blood Pressure	No	Yes
Diabetes	No	Yes	Heart Attack	No	Yes
Stroke	No	Yes	Atherosclerotic Disease (CAD)	No	Yes
Chronic Respiratory Problems	No	Yes	Angioplasty	No	Yes
Epilepsy	No	Yes	Valvular Disease	No	Yes
Arthritis	No	Yes	Stents	No	Yes
Cancer	No	Yes	Arrhythmia	No	Yes
Osteoporosis/Osteopenia	No	Yes	Coronary Artery Bypass (CABG)	No	Yes
Closed Head Injury	No	Yes	Angina	No	Yes
Are you Currently Pregnant?	No	Yes	Pacemaker	No	Yes
			Thyroid	No	Yes

Are you exercising? No Yes Describe: ______________________

Problems with exercise? No Yes Describe: ______________________

What do you hope to accomplish with therapy? ______________________

Significant past or present medical diagnosis and chronic conditions not listed above:

Medications	Diagnosis	Prescribing Physician

Fall History

Injury as a result of a fall in the past? No Yes

Two or more falls in the past year? No Yes

Patient or Responsible Party:

______________________ Date: ______________

OFFICE USE - RTNP VERIFICATIONS:	
Initials	Date

Patient Information

First Name: M.I Last Name: Sex: M F

Address: City, State: Zip:

Home Phone: Work Phone: Cell:

SSN : Date of Birth: Email:

Referring Physician: Primary Care Physician:

Employer Name: Occupation:

Primary Insurance Subscriber Information

First Name: M.I Last Name: Sex: M F

Address: City, State: Zip:

Insurance Carrier: Member ID: Group No:

Relationship to Patient: Employer: SSN:

Secondary Insurance Subscriber Information (if applicable)

First Name: M.I Last Name: Sex: M F

Address: City, State: Zip:

Insurance Carrier: Member ID: Group No:

Relationship to Patient: Employer: SSN:

Responsible Party (if patient is minor)

First Name: M.I Last Name: Sex: M F

Address: City, State: Zip:

Home Phone: Work Phone: Cell:

SSN : Date of Birth: Email:

Employer Name: Patient's Responsibility to Responsible Party:

Emergency Contact:

First Name: Last Name: Realtionship to Patient:

Home Phone: Cell Phone: Work Phone:

Communication Consent

☐ **Option A:** I give Quality Rehab Sols. permission to leave detailed phone messages regarding my medical and/or billing information on:

Home: (Circle) Medical Billing

Cell: (Circle) Medical Billing

Work: (Circle) Medical Billing

I also authorize Quality Rehab Solutions to release **Medical** and/or **Billing** information to : ____________________

☐ **Option B:** I wish to be contacted personally and do not authorize Quality Rehab Solutions to leave detailed messages or discuss my care or billing account with anyone other than myself.

Patient or Responsible Party:

____________________ Date:____________________

OFFICE USE-RTNP VERIFICATION:	
Initials:	Date:

Quality Rehab Solutions
New Patient Forms

SYMPTOM DETAILS

Patient Name: **Date Completed:**

Diagnosis (if you know or have been told): ______________________

____

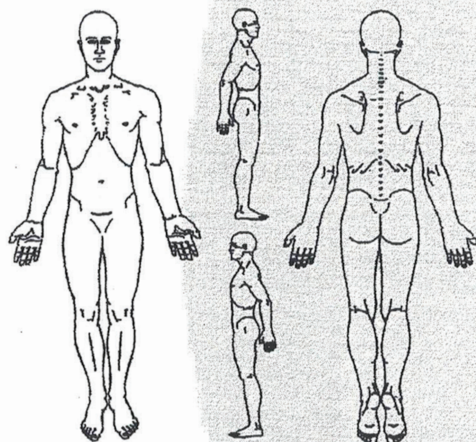
____

Which arm is your dominant arm? ☐ Right ☐ Left

Of the current issues - which side(s) are affected?

☐ Right ☐ Left ☐ Both

Body part effected? (please indicate below)



Shoulder Elbow Wrist Neck Mid-back Low-back
Hip Knee Ankle Other: ______________

Problem(s) (please check all that apply)

☐ Pain
☐ Weakness
☐ Instability/Giving way/Dislocation
☐ Stiffness
☐ Swelling
☐ Other

How severe is your pain? (0=none & 10=severe)

At rest?	0	1	2	3	4	5	6	7	8	9	10
When Active?	0	1	2	3	4	5	6	7	8	9	10
At it's worst ?	0	1	2	3	4	5	6	7	8	9	10
At it's best?	0	1	2	3	4	5	6	7	8	9	10

Do you have pain at night? ☐ YES ☐ NO

Does the pain awaken you from sleep? ☐ YES ☐ NO

Have you been treated for this issue by any other provider(s)? ☐ YES ☐ NO

☐ Physical Therapy # Visits
☐ Occupational Therapy # Visits
☐ Chiropractic # Visits
☐ Home Health # Visits
☐ None

Have you received any injections? ☐ YES ☐ NO

Are you post surgical? ☐ YES ☐ NO

Date of Surgery: ______________________

Type of Surgery: ______________________

List any additional surgeries you've received for this problem:

____

____

____

Other unrelated surgeries: ______________________

____

____

____

How did you injure yourself? (mark all that apply)

☐ No injury -Just started hurting

Date of Onset ______________________

☐ Sport Injury (Which sport?) ______________________

☐ Motor Vehicle Related

☐ Work/Job Related

☐ 3rd Party Accident

Injury: Current Old (greater than 1 year)

Date of Injury: ______________________

Please briefly describe your injury (if applicabile):

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