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| SECTION I: NEW PATIENT INFORMATION  |
| First Name: | Middle:   | Last Name:   | Date of Birth:   | Last 4 Digits of SS#:   |
| Street Address:   | City:   | State:   | Zip:   |
| Home Phone:   | Mobile Phone:  | Work Phone:  | Email: |
| Employer:   | How did you hear about us?   |
| Marital Status:  | Emergency Contact/Relationship:   | Phone:   |
| SECTION II: PATIENT RESPONSIBILTY FOR PAYMENT |
| I WILL NOT GO TO PT AND OT ON THE SAME, AS MY INSURANCE WILL NOT COVER IT. THIS WILL RESULT IN DENIAL OF CLAIMS AND **I WILL BE RESPONSIBLE FOR THE FULL AMOUNT OF THE VISIT.**  |
| IF I AM RECEIVING HOMEHEALTH CARE, I UNDERSTAND MY INSURANCE WILL NOT PAY HAND IN HAND. **I WILL BE RESPONSIBLE FOR THE COST MY THERAPY VISITS.** |
| I WILL NOTIFY HAND IN HAND OF ANY CHANGES IN MY INSURANCE COVERAGE. FAILURE TO DO SO WILL RESULT IN CLAIM DENIAL, **MAKING ME RESPONSIBLE FOR THE COST OF THE THERAPY VISIT.**  |
| SECTION III: CONSENT AND SIGNATURE  |
| **TREATMENT CONSENT**: I CONSENT TO RECEIVE OCCUPATIONAL THERAPY TREATMENT at Hand in Hand Rehabilitation. I understand that therapy is voluntary, that there may be other treatment options, that there may be risks associated with therapy, and that I may request to discuss those risks with my therapist.  |
| **FINANCIAL AGREEMENT/INFO RELEASE**: I AM FINANCIALLY RESPONSIBLE FOR THE COSTS OF MY TREATMENT **and** agree to the policies outlined in “Responsibility for Payment”. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY to Hand in Hand. I AUTHORIZE RELEASE OF ANY PERSONAL OR HEALTH INFORMATION necessary to process insurance claims or to provide and coordinate my treatment. I UNDERSTAND THERE IS A **$25 CHARGE**, PAYABLE BY ME, for appointments cancelled within 24 hours, or for no show appointments.  |
| **PRIVACY**: I HAVE BEEN INFORMED OF MY PRIVACY RIGHTS and have read and understand the document “Health Information Privacy,” provided to me by Hand in Hand Rehabilitation.  |
| Signed:  | Printed Name:  | Today’s Date:  |

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| SECTION IV: MEDICAL AND SOCIAL HISTORY  |
| Referring Physician:  | Date of Next Dr. Visit:  |
| Primary Care Physician:   | PCP Practice/Location:   |
| WHEN did your condition start? | HOW did your injury occur, or your condition begin?  |
| Location of injury? Right Left Are you right or left-handed? Right Left   |
| Because of your problem, what specific activities are you having difficulty with? |
| What are your personal goals you hope to achieve from therapy?   |
| What makes it better?   | What makes it worse?  |
| Have you had prior physical/occupational therapy for this condition? YES NO  |
| Have you had prior physical/occupational therapy this calendar year for any other conditions? YES NO  |
| What do (or did) you do for a living?  | How many hours do (or did) you work in a typical week?  | If you have retired or stopped working, when?  |
| How would you describe your work duties?   |
| Please list prescriptions, over-the-counter medications, or nutritional supplements that you take (or attach a list):   |
| PLEASE LIST ANY KNOWN ALLERGIES:  |
| Do you consume alcohol? If so, how many drinks per week? Do you use any non-prescription substances? i.e. tobacco, marijuana, vaping, opiates, etc? If so, what type and how much per week?  |   |
|   |
|  Describe your general health (check one): EXCELLENT GOOD FAIR POOR  |
| Please list any surgeries: |

Please complete both the pain scale and the symptoms drawing:

**HOW BAD IS YOUR PAIN?**

Please circle the number that corresponds with your pain

0 = No Pain, 10= The Worst Pain

At Worst 0 1 2 3 4 5 6 7 8 9 10

Current 0 1 2 3 4 5 6 7 8 9 10

Best 0 1 2 3 4 5 6 7 8 9 10

**WHERE IS YOUR PAIN NOW?**

Mark the areas on the body drawing where you feel the described sensations. Please use the appropriate symbols. Mark the areas of referred pain. Include all affected areas.

Ache: ^ ^ ^ ^ Numbness: o o o o Burning: x x x x Stabbing: / / / / Pins and Needles: = = = =



**Medical History**

Check **ALL** that apply to you

O No Known Significant Prior Medical History to Affect Treatment

O Alzheimer’s

O Cardiovascular Disease

O Cauda Equina Syndrome

O Cerebral Vascular Accident

O Current Infection

O Diabetes Mellitus Type 1

O Diabetes Mellitus Type 2

O Fibromyalgia

O Fracture or Suspected Fracture

O High Blood Pressure

O History of Cancer

O Huntington’s

O Immunosuppression

O Lupus

O Muscular Dystrophy

O Obesity

O Osteoarthritis

O Parkinson’s

O Rheumatoid Arthritis

O Traumatic Brain Injury

Other Please Describe: