Confidential Medical History/Evaluation

Lebanon Physical Therapy & Rehabilitative Services, L.L.C.

Account #: _____

Name: _____ Date: ____/____/____ Referring MD: _____

Address: _____ Date of Birth: ____/____/____ Phone: _____ SS#: _____

Insurance Company: _____ Subscriber ID: _____ Group #: _____

Insured Employer/Address: _____ Phone: _____

Occupation: _____ Is this injury? Work Related Auto Accident

Chief Complaint: _____ Date of Injury: _____

Current Symptoms: Pain Numbness Stiffness Weakness Condition: New Acute Chronic

List any/all medications you are currently taking: _____

Are you allergic to any medications? _____

List any surgeries: _____

Have you had any Diagnostic or Rehabilitative Services for this Injury? MRI Xrays Other: _____

_____

Do you have any of the following?

	YES	NO
Asthma, Bronchitis or Emphysema	____	____
Shortness of Breath/Chest Pain	____	____
Coronary Heart Disease	____	____
Do you have a Pacemaker	____	____
High Blood Pressure	____	____
Heart Attack/Surgery	____	____
Stroke/TIA	____	____
Blood Clot/Emboli	____	____
Epilepsy/Seizures	____	____
Thyroid Trouble/Goiter	____	____
Anemia	____	____
Infectious Disease	____	____
Diabetes	____	____
Cancer or Chemo/Radiation	____	____
Arthritis/Swollen Joints	____	____
Osteoporosis	____	____
Varicose Veins	____	____
Gout	____	____
Sleeping Difficulties	____	____
Emotional/Psychological Problems	____	____
Bowel or Bladder Problems	____	____
Severe/Frequent Headaches	____	____
Vision/Hearing Difficulties	____	____
Dizziness or Faintness	____	____
Are you pregnant?	____	____
Smoking	Daily _____	Weekly _____
Alcohol Consumption	Daily _____	Weekly _____

Pain when performing the following activities?

	Mild	Moderate	Severe	Unable
Bending	____	____	____	____
Care for Infirm Family	____	____	____	____
Carrying Groceries	____	____	____	____
Change Pos (Sit to Stand)	____	____	____	____
Climb Stairs	____	____	____	____
Driving	____	____	____	____
Extended Computer Use	____	____	____	____
Feeding (Self)	____	____	____	____
Household Chores	____	____	____	____
Kneeling	____	____	____	____
Lift Children	____	____	____	____
Lifting	____	____	____	____
Pet Care	____	____	____	____
Reading (Concentration)	____	____	____	____
Self Care-Bathing	____	____	____	____
Self Care-Dressing	____	____	____	____
Self Care-Shaving	____	____	____	____
Sexual Activities	____	____	____	____
Sleep	____	____	____	____
Sitting (Prolonged)	____	____	____	____
Standing (Prolonged)	____	____	____	____
Walking	____	____	____	____
Yard Work	____	____	____	____

Sports _____

Recreational Activities _____

Exercise Daily _____ Weekly _____

Other Medical Conditions _____

_____

Are you aware of your Diagnosis? YES ___ NO ___ Are you aware of your Prognosis? YES ___ NO ___

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to _____ regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: _____ Date: _____

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: _____ Date: _____