



REHAB CONNECTION

Effective Rehabilitation Using A Hands-On Approach
2861 West Road Trenton, MI 48183
Phone 734-675-2262 / Fax 734-675-3430

Date: _____

Referring Doctor: _____

Account Number: _____

PATIENT REGISTRATION INFORMATION

Last Name: _____ First: _____ M.I. _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Daytime Phone Number: _____ Evening: _____ Cell: _____

Patient email address: _____

Date of Birth: _____ SS# _____ Sex: M ___ F ___

Marital Status: M ___ S ___ D ___ W ___ Spouse's Name _____

Is this injury related to:

Work? Yes ___ No ___ Auto Accident? Yes ___ No ___ Other? Yes ___ No ___

Date of Injury? _____ Is there an attorney involved? Yes ___ No ___

PATIENT WORK INFORMATION

Employer's Name: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone Number: _____ Ext. _____

WORKER'S COMPENSATION INSURANCE / AUTO INSURANCE INFORMATION

Worker's Comp Carrier / Auto Insurance: _____

Address: _____ State: _____ Zip: _____

Insurance Adjuster: _____ Claim Number: _____

Insurance Adjuster's Phone Number: _____

INSURANCE INFORMATION

**PRIVATE INSURANCE INFORMATION
PRIMARY INSURANCE**

Insured Person Name: _____ Is this your coverage? Y ___ N ___

Insured Date of Birth: _____ Relation to Patient _____

Policy Number: _____ Group Number: _____

Insurance Company Name: _____

Phone Number: _____ Contact: _____

SECONDARY INSURANCE

Insured Person Name: _____

Insured Date Of Birth: _____ Relation to Patient: _____

Policy Number: _____ Group Number: _____

Insurance Company Name: _____

Phone Number: _____ Contact: _____

Authorization to Release Information and Assignment of Benefits:

I hereby assign all medical benefits to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance, and any other health plan to **Rehab Connection, Inc.** A copy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment for my services. I also authorize the **Rehab Connection, Inc.** to obtain any testing, reports, physician evaluations or imaging studies that are pertinent to the condition for which I am being treated.

Patient Signature: _____ Date: _____

Guardian / Parent: _____ Date: _____

Please bring the following on your initial visit to our office:
Driver's License / Prescription for therapy from your Doctor / Insurance Cards
Referral Form – If required by your Insurance Plan
Clothing that will allow you to perform exercises.
PLEASE CONTACT THE OFFICE WITH ANY OTHER QUESTIONS
PRIOR TO YOUR SCHEDULED APPOINTMENT

Rehab Connection, Inc. Patient Medical History

Patient's Name _____
Occupation _____

Date _____

When did your symptoms start? _____ (date) Accident / Injury _____ (date)

What caused your current problem? _____

Have you had this problem before? No Yes - When? _____

What has changed in the last 90 days that has made you come to therapy? _____

What activities do you have difficulty with because of your current problem? Self Care / Dressing
 Sleeping / Household Tasks / Hobbies / Sports : i.e. _____ / Driving Bending
 Lifting or Carrying / Work Tasks: i.e. _____ OTHER _____

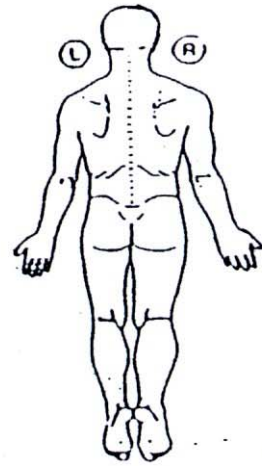
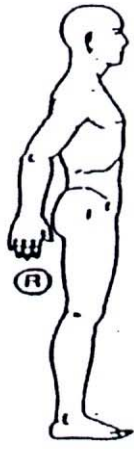
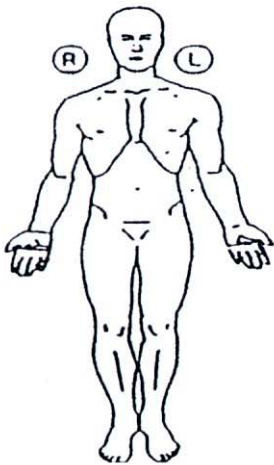
Are your symptoms getting: Better Worse No Change

What makes your symptoms better? (i.e. specific med, position, etc.) _____

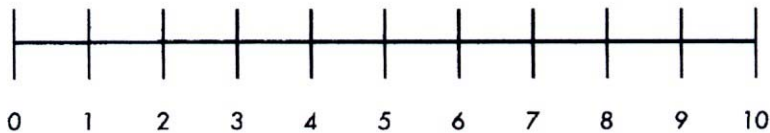
What makes your symptoms worse? _____

Is your pain worse at night? _____ Sleeping position _____

Describe your PAIN: Intermittent Constant Sharp Dull Achy Shooting



Draw the areas of pain (/////); tingling (XXXX); numbness (>>>>>)



0
No pain

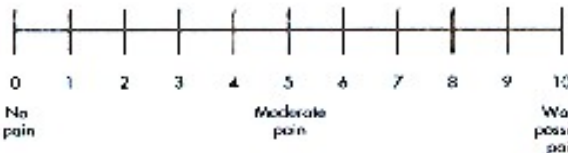
5
Moderate pain

10
Worst possible pain

Circle the number on the graph ABOVE showing your level of pain TODAY (0=NO PAIN / 10=WORST PAIN)

#1

Worst



#2

Best



Circle the number on the graph showing your **HIGHEST** (worst) #1 level of pain...What causes this? _____
Circle the number showing the **LOWEST** (best) #2 level of pain...What position or movement? _____
(0=NO PAIN / 10=WORST)

Tests performed & dates:

X-rays _____ CT Scan _____ MRI _____ EMG _____
Injections / Nerve Blocks _____ OTHER _____

Surgery Dates:

Describe _____ Date _____

Dates of treatment for this problem: Physical Therapy _____ MD / DO _____
Chiropractor _____ OTHER _____

How are you treating your problem at home? (i.e. heating pad, hot showers, ice) Does it help?

What activities or motions are you UNABLE to do now that you could do before the problem began?

Current Medications:

Drug Name	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you now or in the past have had problems with:

- | | |
|-------------------------------------|--------------------------------------|
| _____ Allergies | _____ Asthma |
| _____ Arthritis / Joint Pain | _____ Cancer (_____) where? |
| _____ Circulation / Vascular | _____ Diabetes / High Blood Sugar |
| _____ Head Injury | _____ Heart Problems (_____) what? |
| _____ High Blood Pressure | _____ Heart Attack / MI _____ date? |
| _____ Thyroid (_____) | _____ Stroke _____ when? |
| _____ Stomach / Intestinal | _____ Seizures / Epilepsy |
| _____ Fibromyalgia | _____ Headaches |
| _____ MS / Multiple Sclerosis | _____ Balance – Walking or Standing |
| _____ Posture – Sit / Stand / Sleep | _____ Osteoporosis |
| _____ OTHER _____ | _____ OTHER _____ |

What are YOUR goals to achieve in Physical Therapy?

- | | |
|---------------------------------|--|
| _____ decrease pain | _____ increase joint motion |
| _____ increase strength | _____ increase endurance |
| _____ increase walking distance | _____ improve ability to do daily activities |
| _____ return to work (_____) | _____ return to sports activities (_____) |
| _____ OTHER _____ | _____ OTHER _____ |

TO BE INITIALED BY PATIENT AT COMPLETION OF FIRST VISIT

The therapist has reviewed and discussed with me the findings from the evaluation and has discussed the treatment plan, required frequency of visits, home exercises and new postures required by me to progress in physical therapy and achieve my goals.

Patient's Initials _____ Therapist's Initials _____