PATIENT DATA SHEET

First: **MI:** **Last:**

Date of Birth: Age: Gender: Male ☐ Female ☐

Mailing Address: _____

_____

_____

Physical Address: _____

_____

_____

_____

OK To Call **Phone:** **Best Time To Call**

☐ Home: _____ _____

☐ Work: _____ _____

☐ Cell: _____ _____

SSN:

Email: _____

Would you like to be contacted by email? ☐ Yes ☐ No

Preferred language:

Intepreter required? ☐

☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** ☐ **Unknown**

Student Status: ☐ **Full-Time** ☐ **Part-Time** ☐ **None**

Date of Injury: _____ **Referring Physicain:** _____

Injury Area: _____

Auto or Work Accident: _____

EMPLOYMENT STATUS

Employment Status:
☐ **Active Military** ☐ **Full-Time** ☐ **None** ☐ **Part-Time** ☐ **Retired** ☐ **Self Employed**

PATIENT EMPLOYER INFORMATION

Employer: Occupation:

Address:

Phone:

SPOUSE EMPLOYER INFORMATION

Employer: Occupation:

Address:

Phone:

INSURANCE INFORMATION

Primary Insurance

Policy Holder's Name: Holder's Birth Date:

Policy or Certificate #: Group #:

Policy Holder's Employer:

Secondary Insurance:

Policy Holder's Name: Holder's Birth Date:

Policy or Certificate #: Group #:

Policy Holder's Employer:

Are you receiving or have you received Home Health Services? ☐ Yes ☐ No

Are you receiving or have you received other therapy services? ☐ Yes ☐ No

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other _____

Specify if other : _____

Note: Please provide us with the most updated information down below.

CONTACTS

Name	Phone	Work	Cell	Fax	Type

_____ _____

Signature of Patient **Date**

PATIENT INTAKE AND CONSENT FORM

Please Initial Each as Applicable:

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. _____

TREATMENT OF MINORS:

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

LIABILITY

I know and agree that:

is not responsible for loss or damage to personal valuables. _____

WAIVER AND RELEASE

I hereby release, discharge and acquit:

its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to:

I also authorize release of any medical records necessary to facilitate my treatment to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. _____

NOTICE OF PRIVACY

I acknowledge receipt of Notice of Privacy Practices. _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature_____ Witness Signature _____

BRICK HAND & REHABILITATIVE SERVICES
Occupational & Physical Therapy

MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____
REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____
PRIMARY CARE PHYSICIAN'S NAME: _____ ARE YOU PRESENTLY WORKING? Y ES NO
CAUSE OF INJURY OR ONSET: _____ DATE OF NEXT MD APPT: _____

INJURED AREA: _____ (CIRCLE) RIGHT LEFT BILATERAL

PAIN SCALE: (circle one) WITH MOVEMENT 0 1 2 3 4 5 6 7 8 9 10 WITHOUT MOVEMENT 0 1 2 3 4 5 6 7 8 9 10

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: _____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? _____ WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN_____
AND WHY_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?: _____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: _____

ALLERGIES: Medication _____Reaction_____ Other _____Reaction_____
ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction_____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction_____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- □ ANEMIA
- □ ARTHRITIS
- □ CANCER
- □ CARDIOVASCULAR PROBLEMS
- □ HOLTER MONITOR - currently wearing?
  - □ PACEMAKER
  - □ HIGH BLOOD PRESSURE □ controlled □ uncontrolled
  - □ LOW BLOOD PRESSURE
    - □ CURRENTLY PREGNANT
- □ DIABETES □controlled □uncontrolled
- □ DEPRESSION
- □ DIZZINESS/FAINTING
- □ FRACTURES
- □ HEADACHES
- □ HEPATITIS/HIV
- □ KIDNEY PROBLEMS
- □ MRSA (Methicillin Resistant Staphylococcus Aureus)
- □ OSTEOPOROSIS
- □ RESPIRATORY PROBLEMS
  - □ ASTHMA □ controlled □ uncontrolled
  - □ COPD □ controlled □ uncontrolled
- □ Other
  - □ SEIZURES □ controlled □ uncontrolled
  - □ THYROID PROBLEMS
  - □ BLOOD THINNERS (Anticoagulants)

If checked any above, explain: _____

☐ ANY OTHER MEDICAL PROBLEMS:

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____Date_____

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Person Giving Information: _____ Relationship to Patient: _____
Patient Name: _____
HIC Number: _____
Patient Age _____ Patient Sex _____
Basis for Patient Entitlement to Medicare
_____ Age _____ Disability _____ End Stage Renal Disease (ESRD)

Group Health Plan Information

1. Is the patient or patient's spouse currently employed? _____ Yes _____ No
If No: Retirement date of patient:
Retirement date of spouse:

If Yes, continue.
Is patient or spouse employed?
Are there: _____ 1. Less than 20 employees
_____ 2. More than 100 employees

Is employee actively working? _____ Yes _____ No

Insurance Company: _____
Policy Number: _____ Claim Number: _____
Insurance Plan Name: _____
Plan Identification Number: _____
Is the patient employed? _____ Yes _____ No Full Time? _____ Part Time? _____
Employer Name: _____
Employer Address: _____
City _____ State _____ Zip Code _____
Employer Identification Number: _____

Automobile, No Fault or Liability Insurance Information

2. Is the illness/injury due to an accident (auto included)? _____ Yes _____ No
If Yes, continue.
Type of non-work-related accident: _____ Automobile _____ Other (describe) _____
Date of Accident: _____
Insurance Situation: _____ Liable _____ Not Liable
Name of Policy Holder: _____
Address of Policy Holder: _____
Policy Number or Claim identification Number: _____
Name of Insurance Company: _____
Address of Insurance Company: _____
Name of Patient's Legal Representative for the case if any: _____
Phone Number of Legal Representative: _____

Workers Compensation Insurance Information

3. Was the patient involved in a work-related accident? _____ Yes _____ No
If Yes, continue.

Date of Accident: _____
Is the patient working? _____ Yes _____ No Full Time? _____ Part Time? _____
Employer Name: _____
Employer Address: _____
City _____ State _____ Zip Code _____
Employer Identification Number: _____
Name of Insurance Company: _____
Name of Person or Company Insured: _____
Insurance Company Claim or Policy Number: _____
Workers Compensation Claim Number: _____
Name of Workers Compensation Agency where claim was filed: _____
Address of Agency: _____
Has the case been settled? _____ Yes _____ Date _____ No
Name of Patient's Legal Representative for the case if any: _____
Phone Number of Legal Representative: _____

Veteran's Administration (VA) Authorization Information

Does the patient have a VA fee service card? _____ Yes _____ No
Has the VA issued a special authorization for these services? _____ Yes _____ No
Does the patient authorize you to bill the VA? _____ Yes _____ No

Black Lung Insurance Information

Is the patient entitled to benefits under the Department of Labor's Black Lung Program? _____ Yes _____ No

Are the services provided on the Department of Labor's list of approved procedures for the treatment of Black Lung Disease? _____ Yes _____ No

_____
Patient Signature Date

_____
Witness Signature Date