PATIENT INFORMATION

PATIENT (LEGAL) NAME:_____ SEX:_____ BIRTHDATE:_____

PREVIOUS/MAIDEN NAME(s): _____ SSN:_____ PHONE:_____

PHYSICAL ADDRESS:_____
City State Zip

MAILING ADDRESS:_____ CELL:_____

EMPLOYER:_____ PHONE:_____

SPOUSE NAME:_____ SPOUSE DOB:_____ PHONE:_____

SPOUSE EMPLOYER:_____ SPOUSE WORK PHONE:_____

EMERGENCY CONTACT (OUTSIDE OF HOME):_____ PHONE:_____

EMAIL ADDRESS (FOR APPOINTMENT REMINDERS):_____

HOW DID YOU HEAR ABOUT US?_____

WORK COMP BILLING INFORMATION

WORK COMP CARRIER:_____ CLAIM NUMBER:_____

ADDRESS:_____ PHONE:_____

CLAIMS ADJUSTER:_____ PHONE:_____

DATE OF INJURY:_____ EMPLOYER AT TIME OF INJURY:_____

ATTORNEY:_____ PHONE:_____

SHOULD THE WORK COMP INSURANCE DENY LIABILITY FOR THE CHARGES, WE CAN BILL YOUR PRIVATE INSURANCE

(**Please note**: *Please provide your private insurance information and/or a copy of your Insurance Card.)*

POLICYHOLDER NAME:_____ DOB:_____ RELATION:_____

INSURANCE COMPANY:_____ ID/CLAIM #:_____GROUP #:_____

PLEASE READ -- IMPORTANT INFORMATION

1. I consent to examination, treatment and procedures that may be performed during office visits considered necessary by the physical therapist.
2. I authorize **Advanced Performance and Rehabilitation Services, Inc.** to request information from my attending physician, vocational rehab counselor, employer and/or insurer if needed.
3. I authorize the release of medical information to my Insurance Company and to such other persons/organizations (listed below) as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA).
4. I authorize and request that any insurance benefits be paid directly to **Advanced Performance and Rehabilitation Services, Inc.**
5. I understand that should my Work Comp Insurance deny liability for these charges, I am financially responsible.
6. I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs, will be added to the balance of my account.

ATTENDING PHYSICIAN:_____ VOCATIONAL REHAB COUNSELOR:_____

ATTORNEY:_____ INSURER/INSURER REPRESENTATIVE:_____

EMPLOYER:_____ OTHER:_____

_____ _____

SIGNATURE OF RESPONSIBLE PARTY (PATIENT OR PARENT/GUARANTOR IF PATIENT IS A MINOR) DATE

MEDICAL INFORMATION

NAME: _____ DATE: _____

A. PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS:

1. ARE YOU CURRENTLY ENGAGING IN ANY FORM OF EXERCISE? _____

IF YES, LIST ACTIVITY, FREQUENCY AND INTENSITY: _____

2. HOW ACTIVE IS YOUR LIFESTYLE? _____ SEDENTARY ____ MODERATE PHYSICAL ACTIVITY _____ HEAVY PHYSICAL ACTIVITY

3. WHAT IS YOUR JOB TITLE IF CURRENTLY WORKING?_____
DESCRIBE THE TYPES OF ACTIVITIES INVOLVED IN YOUR JOB (HEAVY LIFTING, STAIR CLIMBING, WALKING, SITTING AT DESK, ETC):

_____

_____

4. PLEASE INDICATE YOUR EXPECTATIONS AND GOALS FOR YOUR TREATMENT:_____

_____

B. **PLEASE FILL OUT YOUR PAIN LEVELS AND MARK WHERE YOU ARE FEELING THE PAIN ON THE DIAGRAM BELOW.**

PAIN / DISCOMFORT/DIZZINESS DESCRIPTION

SYMPTON FREQUENCY:

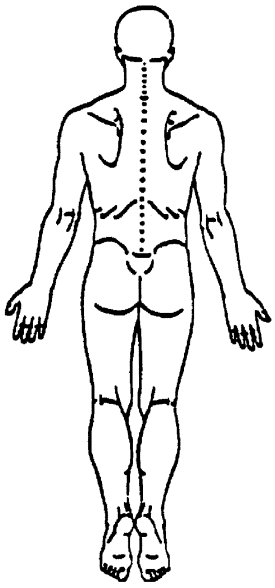
_____ CONSTANT
_____ COMES AND GOES AT REGULAR TIMES
_____ HAPPENS ONCE IN A WHILE

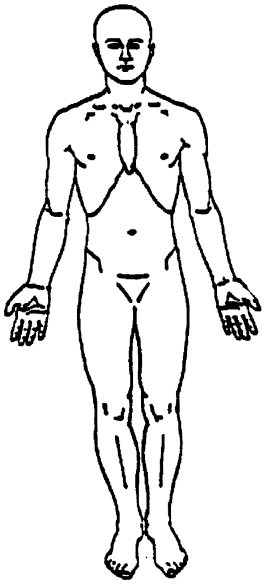
RELATIONSHIP OF SYMPTOMS TO SLEEP:

_____ WAKES FROM SLEEP
_____ PREVENTS SLEEP
_____ BETTER AFTER SLEEP

SYMPTOM SCALE-	0 BEING NONE AT ALL										10 BEING AS BAD AS IT CAN BE
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
AT BEST	0	1	2	3	4	5	6	7	8	9	10

Key: /// Stabbing XXX Burning 000 Pins & Needles === Numbness





PATIENT SIGNATURE: _____ DATE:_____

MEDICATION INFORMATION

NAME:________________________________ **DATE**:____________________

MEDICAL HISTORY:

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

_____	ALZHEIMER'S	_____	HIGH BLOOD PRESSURE	_____	OSTEOARTHRITIS
_____	CARDIOVASCULAR DISEASE	_____	HISTORY OF CANCER	_____	PARKINSON'S
_____	CURRENT INFECTION	_____	HUNTINGTON'S	_____	PREGNANT/POSSIBLY PREGNANT
_____	CVA/STROKE	_____	LUPUS	_____	RHEUMATOID ARTHRITIS
_____	DIABETES TYPE 1/TYPE 2 (CIRCLE)	_____	MUSCULAR DYSTROPHY	_____	TRAUMATIC BRAIN INJURY
_____	FIBROMYALGIA	_____	HIV, HEPATITIS B, HEPATITIS C		

_____ PREVIOUS FRACTURED BONES (IF SO WHICH ONES):____

OTHER:____

PLEASE LIST BELOW YOUR CURRENT PRESCRIPTION(S), OVER-THE-COUNTER, HERBAL, VITAMIN/ MINERALS / DIETARY (NUTRITIONAL SUPPLEMENTS) MEDICATIONS. IF YOU HAVE A CURRENT LIST OF YOUR MEDICATIONS WITH ALL OF THE BELOW INFORMATION, PLEASE PROVIDE IT TO THE FRONT OFFICE AND THEY CAN MAKE A COPY.

PRESCRIPTION MEDICATIONS:

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

OVER-THE-COUNTER / HERBAL/ VITAMIN /MINERAL / DIETARY (NUTRITIONAL SUPPLEMENT):

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

For Future Appointments Only

I ___________________________, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:____ DATE:________________

I ___________________________, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:____ DATE:________________

I ___________________________, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:____ DATE:________________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

I, _____, acknowledge that Advanced Performance and Rehabilitation Services office has a posted Notice of Privacy Practice available in the patient reception area. A copy is available by request.

_____ _____

Signature Date

AUTHORIZED RELEASE OF INFORMATION

Patient Name:

I have been referred to Advanced Performance and Rehabilitation Services, Inc. for evaluation and treatment for my on-the-job injury. I understand that signing this form authorizes the release to the workers' compensation insurer or its agent, rehabilitation records, Social Security records, and health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA) that are directly relevant to the claimed injury, disease or death.

_____ _____

Signature Date