REHABILITATION & Performance Center
PHYSICAL THERAPY

RETURNING PATIENT / NEW CASE

Patient name _____ Date of Birth _____

***Is this visit the result of a WORK INJURY or AUTO ACCIDENT** YES ☐ NO ☐ If no, skip section and go to **Payment Information**

Do you have an attorney? Y ☐ N ☐ Employer name: _____ Occupation: _____

Is this visit due to a work injury or auto accident? Y ☐ N ☐ Accident/Injury Date: _____

PAYMENT INFORMATION (check ONE of the following boxes)

☐ **CASH PAYER / I DO NOT have insurance** and I will pay out of pocket with cash, check, or credit card for services. A $35.00 fee will be charged to my account for returned checks and may result in RPC asking for a different form of payment. I will speak with staff about payment options available.

☐ **INSURANCE / I HAVE insurance** and want RPC to file all claims for services. I will assign all benefits to RPC and I understand I am responsible for my deductible, co-payment &/or coinsurance associated with my insurance plan for each date of service. I understand that I am financially responsible for any non-covered service(s). It is my responsibility to know my insurance policy and to notify this practice of any changes to my policy and/or coverage.

Primary Insurance: _____ Are you the primary policy holder? Y ☐ N ☐

Policy#: _____ Group#: _____

Secondary Insurance: _____ Are you the primary policy holder? Y ☐ N ☐

Policy#: _____ Group#: _____

Have you had PT this year? Y ☐ N ☐ If yes, where _____

Do you live in a Nursing Home? Y ☐ N ☐ If yes, where _____

Are you covered under Black Lung Disease? Y ☐ N ☐ Do you receive Home Health Services? Y ☐ N ☐
Are you covered under End Stage Renal Disease? Y ☐ N ☐

PRIVACY, RIGHTS, & POLICY ACKNOWLEDGEMENT

As a returning patient, I acknowledge that I have received a copy of Rehabilitation and Performance Center's following notices, rights, and policies: 1) Privacy Notice / Patient Rights
2) Cancellation/No Show Policies.

The above information has been reviewed and I have been given opportunity to have questions answered to my satisfaction. I understand that if I need a new copy of the items listed above, they can be requested through Rehabilitation and Performance Center's front office at any time.

Patient / Responsible Party Signature _____ Date _____

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Legal Name: _____ Gender: M F Age: _____

Leisure Activities: _____ Height: _____ Weight: _____

Referring Doctor: _____ Returning appointment date: _____

Currently seen by: ☐ Medical Doctor ☐ Psychiatrist/Psychologist ☐ Dentist ☐ Physical Therapist ☐ Chiropractor ☐ Osteopath

Onset of current injury/symptoms (date) _____

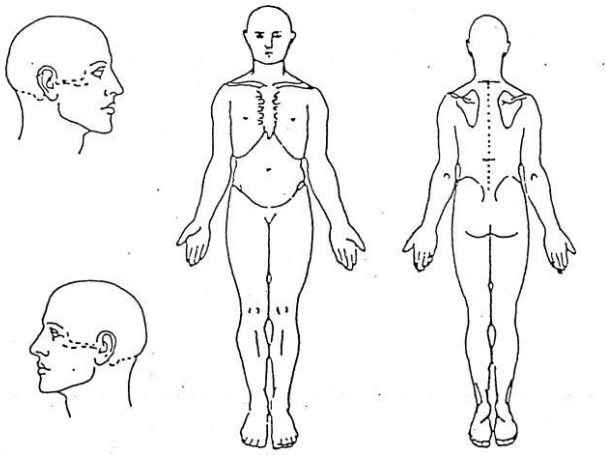
Have you had surgery as a result of your current injury? ☐ Yes ☐ No If yes, date of surgery: _____

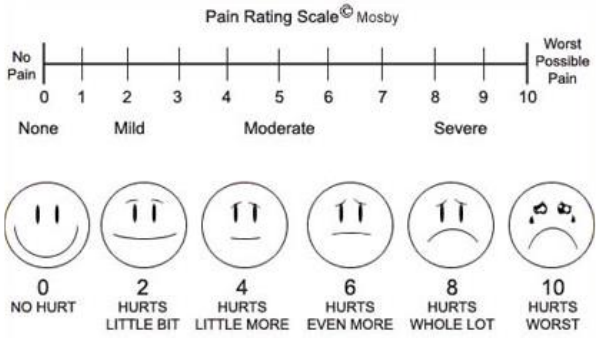
Have you had physical therapy for the current injury/symptoms? ☐ Yes ☐ No

Describe current injury / symptoms: _____

Allergies	Yes	No	Gallbladder Problems	Yes	No
Anemia	Yes	No	Hepatitis	Yes	No
Anxiety	Yes	No	High Blood Pressure	Yes	No
Arthritis	Yes	No	Incontinence	Yes	No
Asthma	Yes	No	Kidney Problems	Yes	No
Cancer	Yes	No	Metal Implants	Yes	No
Cardiac Conditions	Yes	No	Multiple Sclerosis	Yes	No
Cardiac Pacemaker	Yes	No	Osteoporosis	Yes	No
Chemical Dependency	Yes	No	Parkinson's	Yes	No
Circulation Problems	Yes	No	Rheumatoid Arthritis	Yes	No
Currently Pregnant	Yes	No	Seizures	Yes	No
Depression	Yes	No	Speech Problems	Yes	No
Diabetes	Yes	No	Strokes	Yes	No
Dizzy Spells	Yes	No	Thyroid Disease	Yes	No
Emphysema/Bronchitis	Yes	No	Tuberculosis	Yes	No
Fractures	Yes	No	Vision Problems	Yes	No
Falls	Yes	No			
2 or more Falls in past year	Yes	No			

Please circle the locations of your pain





Other conditions the physical therapist should know about that are not listed above? If yes, please provide:

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Patient Legal Name: _____ **Date:** _____

Allergies: ☐ **None** **List allergies here:** _____

_____

CURRENT PRESCRIBED MEDICATIONS:

Medication Name	Reason taken	Dose	Frequency	Route

SURGICAL HISTORY

Body Region	Surgery Type	Date / Year of surgery

Your signature acknowledges that all information given is accurate and truthful to the best of your knowledge.

Patient / Responsible Party Signature _____ Date _____