Patient Information

_____(____)_____-_____(____)_____-_____
Patient Last Name First Name Middle Initial Home Phone number Cell Phone Number

_____
Street Address City State Zip

____/___/_____-____-_____
Date of Birth Age Sex Social Security Number Marital Status

If you would like to receive a reminder by email, text or voice call for your visits, provide the info below: (Circle one)

E-mail Address:_____ Phone (_____)_____-_____

_____(____)_____-_____
Employer's Name Employer's Phone

_____(____)_____-_____
Name of Primary Care Physician Primary Care Physicians Phone Number

_____(____)_____-_____
Referring Doctor Referring Doctor Phone Number

_____
How did you hear about our facility?

SPOUSE/ PARENT *(IF NOT MARRIED)* **INFORMATION**

_____
Last Name First Name Initial Date of Birth

_____(____)_____-_____
Their Employer's Name Employer's Phone

WHO CAN WE CALL IN CASE OF AN EMERGENCY

_____(____)_____-_____
Their Name Relation to Patient Phone Number

***** Is my referral due to a Workers Comp, Motor Vehicle Accident, or Slip and Fall Personal Injury? Yes No Circle one if Yes**

9716 Riverside Pkwy Suite 201 Tulsa, OK 74137
Phone: 918-749-0003 Fax: 918-749-0210

Patient Information

*****Please present your insurance card to the receptionist when you hand in your paper work. Thank you.*****

Primary Insurance Company Name | Policy Number | Group Number

Policy Holder's Name (from card) | Social Security Number | Date of Birth

Secondary Insurance Company Name | Policy Number | Group Number

Policy Holder's Name (from card) | Social Security Number | Date of Birth

RESPONSIBILITY STATEMENT & RELEASE OF INFORMATION

I understand that I am responsible for paying for all medical services not covered by an authorization/agreement between Physical Rehabilitation Center on Riverside and my insurance carrier or attorney. I authorize the release of any or all of the patient's medical records for this period of care to any person/corporation liable for any part of the physician charges and the patient's attorney. Oklahoma state law requires that we advise "The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS)."

Print Patient or Legal Guardian Name

Patient or Legal Guardian Signature | Date

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Patient Health Questionnaire

Name: _____ Nickname: _____ Date:_____

Age: _____ Date of Birth: _____Height: _____ Weight: _____

Occupation:_____ Employer:_____

How did you hear about our facility? [ ] Physician Referral [ ] Past Patient [ ] Internet

[ ] Signage [ ] Friend or Family [ ] Other_____

How did problem occur? _____ [ ] Unknown

When did symptoms begin? Month _____ Day_____ Year_____

[ ] Within the past month [ ] Within the past year [ ] Ongoing for over a year

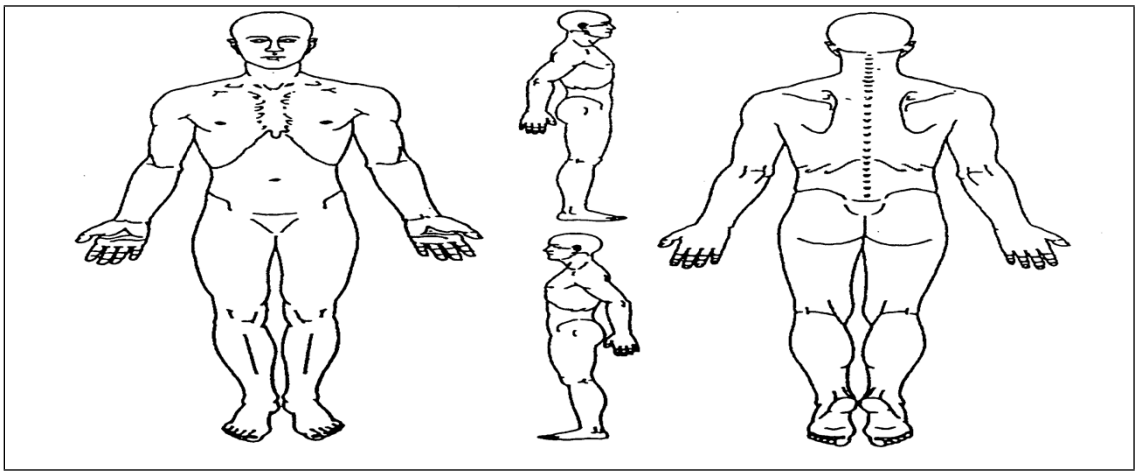
Have you had a MRI of your injury? [ ] Yes, [ ] No

Which body part(s) _____,What MRI Facility_____

Did you have surgery for this condition? [ ] Yes, [ ] No Surgeon Name _____

Date of surgery: Month _____ Day_____ Year_____

***On below chart please mark (X) location of your injury that you were referred for treatment**:



Please rate your pain on a scale of 0 – 10 with (0) being no pain and (10) being the worst.

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

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Describe your pain: (Mark only the **one** that best describes)

[ ] Sharp, [ ] Dull / Achy, [ ] Burning, [ ] Shooting, [ ] Numbness/Tingling, [ ] Constant,

[ ] Intermittent [ ] Worse in am, [ ] Worse in pm

Aggravating Factors: [ ] Sitting, [ ] Standing, [ ] Walking, [ ] Stairs, [ ] Sit to stand, [ ] Bending,

[ ] Lifting, [ ] Sleeping, [ ] Squatting, [ ] Carrying, [ ] Reaching Overhead, [ ] Handling objects,

[ ] Pushing, [ ] Pulling, [ ] Running, [ ] Jumping, [ ] Exercise

Alleviating Factors: [ ] Sitting, [ ] Standing [ ] Walking, [ ] Lying Down, [ ] On the move,

[ ] When still, [ ] As the day progresses

What other treatment are you receiving for this condition? [ ] Medication [ ] Injections

[ ] Chiropractic [ ] Other: Doctor Name: _____ and Specialty _____

Medications related to your injury: [ ] Prescription pain, [ ] Over the counter pain,

[ ] Anti-inflammatory, [ ] Other _____

Check if you have, or have ever had any of the following conditions:

[ ] Abdominal Aneurysm, [ ] Pacemaker, [ ] Diabetes Type 1, [ ] Diabetes Type 2 [ ] Stroke

[ ] High Blood Pressure, [ ] HIV (+), [ ] Heart Attack, [ ] Fibromyalgia, [ ] Rheumatoid Arthritis,

[ ] Osteo Arthritis [ ] Currently Pregnant [ ] Cancer, What type_____ [ ] Are you in remission

Please list other pertinent medical conditions that might affect your treatment:

_____

What is your primary goal in Physical Therapy:_____

_____

Patient Name:_____

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