Back-in-Action
REHABILITATION, S.C.

Patient Name:
DOB:
Acct #:
Date:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
ASSIGNMENT OF BENEFITS

I hereby authorize Back-in-Action Rehabilitation to provide treatment, release information pertaining to my treatment for insurance purposes: and/or receive direct insurance payments otherwise payable to me for services rendered. I understand that I am financially responsible for payment of all services; including those charges not covered by my insurance. I also acknowledge I have had full opportunity to read and consider the contents of the Privacy Notice. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

Signature_____ Date_____

Other than your doctor, how did you hear about us? (Check all that apply)

Newspaper
- ☐ Action Advertiser
- ☐ The Reporter
- ☐ Tri-County News
- ☐ Chilton Times
- ☐ Statesman
- ☐ Other Newspaper
- ☐ Phonebook

Radio
- ☐ KFIZ 107
- ☐ WFDL 97
- ☐ WTCX 96
- ☐ WMDC 98.7
- ☐ Other Radio Station

Other
- ☐ Billboard
- ☐ Building Sign
- ☐ Drove by
- ☐ Back in Action Website
- ☐ Other

_____

☐ If you heard about us through a friend or relative, may we have their name so we may thank them?

_____

EMERGENCY CONTACT INFORMATION

Name:_____

Relationship:_____

Phone #:_____ ☐ Work ☐ Home

Alternate Phone #:_____ ☐ Work ☐ Home

Back-in-Action REHABILITATION, S.C.

Patient Health History Questionnaire

To ensure you receive a complete and thorough evaluation, please provide us with the important background information requested on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

NAME: **DOB**: **Date**:

OCCUPATION, including activities that comprise your workday: _____

LEISURE ACTIVITIES, including exercise: _____

AGE: _____ **HEIGHT**: _____ **WEIGHT**: _____

ALLERGIES: List any medications you are allergic to:_____

Are you latex sensitive? YES NO — List any allergies we should know about: _____

Do you smoke? YES NO — Do you have a pacemaker? YES NO

Do you drink Alcohol? YES NO — How many alcoholic beverages do you drink per week? _____

Do you take blood thinners? YES NO — Do you have any implants? YES NO

Have you had a recent illness (explain if yes)? _____

FOR WOMEN: Are you currently pregnant or do you think you might be pregnant? YES NO

Have you recently experienced any of the following (check all that apply)?

☐ Fatigue	☐ Numbness or tingling	☐ Constipation	
☐ Fever/chills/sweats	☐ Muscle weakness	☐ Diarrhea	
☐ Nausea/vomiting	☐ Dizziness/lightheadedness	☐ Shortness of breath	
☐ Weight loss or gain	☐ Heartburn/indigestion	☐ Fainting	
☐ Falls	☐ Difficulty swallowing	☐ Cough	
☐ Balance difficulty	☐ Changes in bowel or bladder function	☐ Headaches	☐ No to all

Have you ever been diagnosed as having any of the following conditions?

☐ Cancer	☐ Lung disease	☐ Depression/Anxiety	
☐ Heart Problems	☐ Tuberculosis	☐ Chemical dependency	
☐ High Blood Pressure	☐ Asthma	☐ Bone or joint infection	
☐ High Cholesterol	☐ Rheumatoid arthritis	☐ Diabetes	
☐ Circulation Problems	☐ Other arthritic conditions	☐ Osteoporosis/Osteopenia	
☐ Angina/Chest pain	☐ Bladder/urinary tract infection	☐ Multiple Sclerosis	
☐ Blood clots	☐ Kidney Problem/infection	☐ Epilepsy	
☐ Stroke	☐ Sexually transmitted disease/HIV	☐ Ulcers	
☐ Anemia	☐ Pelvic inflammatory disease	☐ Liver disease	
☐ Pneumonia	☐ Hepatitis	☐Other_____	☐ No to all

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

☐ Cancer	☐ Diabetes	☐ Tuberculosis	
☐ Heart disease	☐ Stroke	☐ Thyroid Problems	
☐ High blood pressure	☐ Depression	☐ Blood Clots	☐ No to all

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to harm you in any way? **YES NO**

Please list any surgeries or conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE	REASON FOR SURGERY/HOSPITALIZATION	DATE	REASON FOR SURGERY/HOSPITALIZATION
1.		4.	
2.		5.	
3.		6.	

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

☐ Aspirin ☐ Laxatives ☐ Antacid
☐ Tylenol/Acetaminophen ☐ Decongestants ☐ Vitamins/mineral supplements
☐ Advil/Motrin/Ibuprofen ☐ Antihistamines ☐ Other_____

Please list any PRESCRIPTION medication that you are taking (including pills, injections, and/or skin patches):

1._____ 3._____ 5._____
2._____ 4._____ 6._____

CURRENT SYMPTOMS: Briefly describe your symptoms: _____

When did your symptoms start (approx date)? _____ How? (Was there an injury)? _____

Have you previously been treated for this condition? YES NO By whom? _____

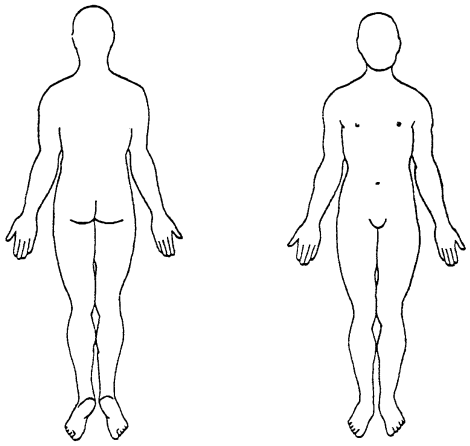
What is your personal goal for therapy? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

No symptoms 0 1 2 3 4 5 6 7 8 9 10 **Need to go to the hospital**

Body Chart: Please color in any areas where you feel symptoms on on the chart to the right



Using the 0-10 scale above, rate the level of symptoms that you have (had):
Currently: _____
Average in last 24 hours: _____
Average pain in last week: _____

How often do you experience your symptoms?

☐ **Constantly (76-100% of time)** ☐ **Frequently (51-75% of time)** ☐ **Occasionally (26-50% of time)** ☐ **Intermittently (0-25% of time)**

My symptoms are (check one):

☐ **getting better** ☐ **not changing** ☐ **getting worse** ☐ **fluctuating**

How much have our symptoms interfered with your usual daily activities? (both work outside of the home and housework)

☐ **Not at all** ☐ **A little Bit** ☐ **Moderately** ☐ **Quite a bit** ☐ **Extremely**

In general, would you say your overall health right now is…

☐ **Excellent** ☐ **Very Good** ☐ **Good** ☐ **Fair** ☐ **Poor**

Identify up to three important activities that you are unable to do or are having difficulty with as a result of your problem.

1._____
2._____
3._____

Therapist use only
1. PSFS rating _____
2. PSFS rating _____ PSFS Avg _____
3. PSFS rating _____

Therapist use only

Unable to perform actvitity 0 1 2 3 4 5 6 7 8 9 10 **Able to perform activity at same level as before your injury or surgery**

_____ _____
Patient Signature Date Therapist Signature Date