Therapy Screening

Patient Name: _____ **Date of Birth:** ______**Date of Visit:** _____

Patient address: _____ _____ _____, _____ **Phone number:** _____

Do you have a primary care physician or currently under the care of a physician? Yes No

Name of primary care physician or physician____

Would you like the results of your visit today sent to your primary care physician or physician ? Yes No

EMERGENCY CONTACT INFORMATION

Name: _____ _____

Relationship: _____

Phone #: _____

Alternate Phone #:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION ASSIGNMENT OF BENEFITS

I hereby authorize Back-in-Action Rehabilitation to provide treatment and to release information pertaining to my treatment as necessary. I understand that, by signing this form, I am confirming my written permission for the discloser of my protected health information, as described in this form. If under the age of 18, please have parent or guardian sign for authorization of treatment.

Patient/Parent Signature: ____ Date: _________________________________

Back-in-Action
REHABILITATION, S.C.

Please answer the questions to the best of your ability based on how you feel today. It may be necessary to observe certain precautions during your treatment if any of the following medical conditions exist. Thank you for your cooperation.

Patient Name: Date of Birth: Date of Visit:

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

☐ High blood pressure ☐ Cancer ☐ Currently pregnant ☐ Dizziness

☐ Pacemaker ☐ Diabetes ☐ Heart condition ☐ Stroke

☐ Metal implants ☐ Loss of sensation ☐ Circulation problems

☐ History of seizures ☐ Drug allergies Please list: ___________________________________
____

☐ Infectious diseases such as tuberculosis, hepatitis A,B or C, HIV, etc.

Please list: ____
____

Do you smoke? ☐ Yes ☐ No

What is the condition that brought you to seek treatment? ____
____

Have you ever been treated before for this condition? ____
____

What is your goal for improvement? ____

List dosage and frequency of medications including over-the-counter, herbals, vitamins/mineral/dietary or nutritional supplements you are currently taking: ____
____

List any surgeries you have had ____
____
____

Please indicate your range of pain by circling the number when it is at its lowest level and when it is at its highest level. (0=least pain; 10=most pain)

0 1 2 3 4 5 6 7 8 9 10

Circle the words that best describe your pain:

Constant frequent occasional aching stabbing burning throbbing shooting

What makes your pain worse?____

What makes your pain better?____

Patient Signature: ____

Therapist Signature: ____