Patient Name: _____ MRN: _____ PN: _____

Patient History Form

In order to provide you with the highest quality care, it is important for us to have a thorough health history. This information will remain a confidential part of your medical record. Please fill out the following information.

Primary Care MD: _____ Height: _____ Current Weight: _____ Age: _____

Condition	Yes	No	Condition	Yes	No	List all medications you currently take or ask us to copy your list.
Tuberculosis			Fainting/Dizziness/Falls/Imbalance			
Cancer			Pregnancy			
Ulcers			Hernia			
Low/High Blood Pressure			Fracture			
Bowel/Bladder Problems			Alcoholism/ Chemical Dependency			
Neck Injury			Blood Clots			
Back Injury			Kidney Disease			
Arthritis/Joint Swelling			Epilepsy/Seizures			
Headaches/Migraines			Do you exercise regularly?			
Hepatitis			Do you smoke?			
Allergies/Asthma			Are you in a relationship where you are being hit, kicked, slapped or otherwise hurt?			
Heart Problems/ Pacemaker/Chest Pain						
Diabetes/Neuropathy			Hearing Loss/Ringing in ears?			
HIV/AIDS			Cataracts /Glaucoma /Macular Degeneration			
Stroke/Head/Brain Injury						
Shortness of Breath			Do you feel safe at home?			

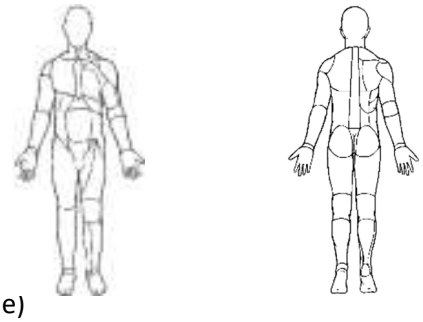
Briefly describe your symptoms: _____

_____

How did your symptoms start? _____

_____

Indicate where you have pain/other symptoms:



Average Pain Intensity (Circle one per line):

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past Week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How often do you experience your symptoms? (Check one)

☐ Constantly (76%-100% of the time) ☐ Frequently (51%-75% of the time)

☐ Occasionally (26%-50% of the time) ☐ Intermittently (0%-25% of the time)

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

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

How is your condition changing, since care began at this facility?

☐ N/A – Initial visit ☐ Much worse ☐ Worse ☐ A little worse ☐ No change ☐ A little better ☐ Better ☐ Much better

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

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Patient Signature _____ **Date** _____

Patient Name: _____MRN: _____ PN: _____

Orthopedic Rehabilitation Associates Cancellation/No Show Policy

And

Notice of Privacy Practices

The Staff at Orthopedic Rehabilitation Assocaites work hard to provide quality care and to give each patient the time required for their condition. We offer early morning and evening hours for those whose schedules do not allow treatment during the day.

As our business grows, it becomes increasingly important that we continue to offer treatment time slots that are as convenient as possible to our patients. It is equally important that if you wish to cancel or reschedule an appointment that we receive at least 24 hours notice so that we can call and schedule patients from our waiting list. We do realize that scheduling conflicts and emergency situations occasionally arise and we will do our best to excuse these special circumstances.

A $25 Cancellation/NO Show Fee will be charged to your directly. These fees cannot be billed to insurance.

A voice message on our phone is an acceptable means to communicate a cancellation within 24 hours of your scheduled appointment.

Thank you in advance for your consideration.

I have read and understand Orthopedic Rehabilitation Associates Cancellation/No Show Policy

_____ _____

Patient/Responsible Party Signature Date

Notice of Privacy Practices

I hereby acknowledge that I have read and received Orthopedic Rehabilitation Associates Notice of Privacy Practices.

_____

Printed Name of Patient

_____ _____

Signature of Patient or Guardian Date