Please bring prescription for therapy and
your insurance card to be copied. Thank you.

MOUNTAIN TOWN REHAB

Patient Information

Name: _____ Date of Birth: _____
(Last) (First) (MI)

Home Phone: _____ Cell Phone:_____

Home Address: _____
(Number & Street) (City) (State) (Zip Code)

Mailing Address (If different): _____

Employer: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Employer: _____

Person to notify in emergency: _____ Relationship: _____ Phone #: _____

If a minor, name of parent or legal guardian: _____

Referring Physician:_____ Reason for Referral: _____ Date of Onset: _____

Have you had physical therapy this calendar year? _____ When: _____# of visits?: _____

Have you had traction in a chiropractic office this year? _____ When: _____ Where: _____

Insurance Information

If this injury is due to an automobile accident or is work related, please complete the information below:

Automobile Insurance Company: _____
Address: _____
Phone #: _____ Date of Injury: _____
Contact Person: _____
Claim #_____

Workers' Compensation Carrier: _____
Address: _____
Phone #: _____ Date of Injury: _____
Contact Person: _____
Claim #: _____

I hereby give **Mountain Town Rehab** permission to provide treatment as prescribed by my physician. I understand and agree that I am ultimately responsible for any co-payments and/or deductible or any professional services rendered that are not payable by my insurance company. I have completed the above questions and I certify that this information is true and current to the best of my knowledge. I will notify you of any changes in my health status or the above information.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or other medical person/entity.

Signature of Patient or Guardian: _____ Date: _____

MOUNTAIN TOWN REHAB

NAME_____ DATE_____

Have you or any immediate family member (parents/siblings) ever been told you have:

	Self		Family	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High Blood Pressure?	Yes	No	Yes	No
Heart Disease?	Yes	No	Yes	No
Angina/Chest Pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid Arthritis?	Yes	No	Yes	No

In the past 3 months have you had or do you experience:

A change in your health?	Yes	No
Nausea/Vomiting?	Yes	No
Fever/Chills/Sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness or Tingling?	Yes	No
Change in appetite?	Yes	No
Difficulty in swallowing?	Yes	No
Changes in bowel or bladder function?	Yes	No
Shortness of breath?	Yes	No
Dizziness?	Yes	No
Upper Respiratory Infection?	Yes	No

Are you currently:

Pregnant?	Yes	No
Depressed?	Yes	No
Under stress?	Yes	No

Check all that apply…I currently have difficulty:

☐ Walking ☐ Standing ☐ Driving ☐ Lifting

☐ Getting up from a chair ☐ Bending at the waist

How are you able to sleep at night? (check one)

☐ Fine ☐ Moderate difficulty ☐ Only with medication

If you are accustomed to regular exercising, check the ones that give you difficulty now:

☐ Playing Sports ☐ Running ☐ Stretching

Do you have a history of:

Seasonal Allergies/Asthma?	Yes	No
Headaches?	Yes	No
Bronchitis?	Yes	No
Kidney Disease?	Yes	No
Rheumatic Fever?	Yes	No
Ulcers?	Yes	No
Sexually transmitted diseases?	Yes	No
Seizures?	Yes	No
Hepatitis?	Yes	No
TB?	Yes	No
Blood Clots?	Yes	No
MRSA/Staph?	Yes	No

Are you allergic to or sensitive to latex?

YES NO

What have you done/whom have you seen for this specific diagnosis?_____

Are your symptoms: (check one)

☐ Getting worse ☐ The same ☐ Improving

Check all that apply…Do you have a problem with:

☐ Hearing ☐ Vision ☐ Speech ☐ Communication

Do you or have you in the past smoked tobacco?

YES NO

If yes, _____packs a day X _____years.

Last tobacco use_____.

Do you drink alcoholic beverages?

YES NO

If yes, _____/week.

Date of last physical examination:_____

List any previous surgeries/dates:_____

_____

_____

Medication List and Allergies – See Page 4:

If you are currently taking medications (prescriptions, over-the-counter medications, vitamins, supplements, and herbals) or if you have allergies, please complete page four of this form.

MOUNTAIN TOWN REHAB

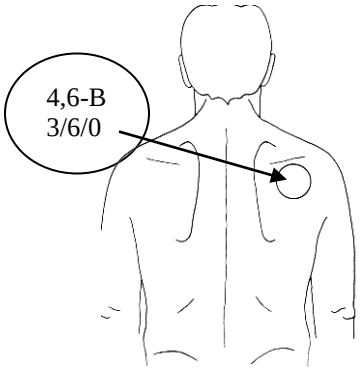
NAME_____ DATE_____

Please Create a Chart of Your CURRENT Symptoms (see example)

This list provides some examples of words that may help describe your pain. Use ALL that apply.

1 – Sharp	7 – Tingling
2 – Shooting	8 – Numb
3 – Burning	9 – Heavy
4 – Dull	10 – Tight
5 – Throbbing	11 – Pulling
6 – Ache	12 – Stabbing

EXAMPLE



This list provides some examples of words that may help describe the behavior of your symptoms.

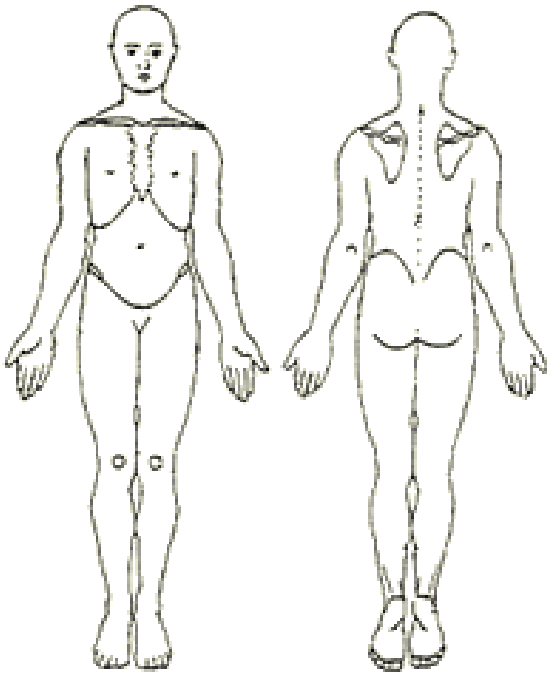
A. constant (never goes away)
B. intermittent (relieved with some positions or rest)
C. occasionally (daily or less frequent)
D. infrequently (once a week or month)
E. previously (no longer present)
F. variable (sometimes worse than others)

INSTRUCTIONS

1. Draw each area of your pain or other symptoms on the chart.

2. Choose the corresponding number and letters from the previous lists to describe your symptoms or use your own words.

3. Put the date each area of symptoms started, <u>for this episode,</u> to the best of your memory.



MOUNTAIN TOWN REHAB

NAME_____ DATE_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.

Include prescriptions, over-the-counter medications (aspirin, antacids...), vitamins, supplements, and herbals. Include medications taken as needed (example: nitroglycerin).

Medication	Purpose	Dosage	Frequency	Route
Example: Metformin	*diabetes*	*500 mg*	*2x a day*	*oral*

Allergic To:	Describe Reaction: