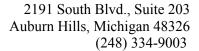




PATIENT INFORMATION	MATION			EMAIL ADDRESS:							
First Name:	Last Name:					Middle Initial:			Date: / /		
Address:				City:		St		Stat	te:	Zip:	
Birth date: / /	Age:			Male	□ F	Female S.S.			#:		
Home Phone: ( ) -	Alterr	native Pho	ne (Ce	ell, Pag	ger):	( )	-		Spou	ise:	
Chose Clinic Because/ Referred to Clin	nic By 🗆 Dr	• •				Insurance	Plan	□ Fa	mily 🗆 l	Friend	
☐ Former Patient ☐ Close to Work/H	Iome 🗆 We	ebsite 🗆 Y	<i>Y</i> ellow	/ Pages	s 🗆	Street Sign		ther:			
WORK INFORMATION											
Employer:						Work Phor	ne (	)	-		Ext.
Occupation:	Eı	mploymen	t Statı	us 🗆	Full	Time □ Pa	rt Tir	ne 🗆	Retired	□ Not	Employed
CARE PROVIDER INFORMAT	ION										
Referring Dr:						Referring l	Dr. P	hone: (	( )	-	
Regular Dr./PCP						Regular D	r./PC	P Phor	ne: (	)	-
INSURANCE INFORMATION		(PLEAS	SE GI	VE YO	UR I	NSURANCI	E CA	RD TO	THE RE	CEPTI	ONIST)
Primary Insurance Name:											
Subscriber's Name (If different):						Birth Date : / /					
ID. #: Group/Policy #											
Patient's Relationship to Subscriber: $\square$ Self $\square$ Spouse $\square$ Child $\square$ Other:											
Name of Secondary Insurance:											
Subscriber's Name:								Birth Da	te:	/ /	
ID. #: Group/Policy #											
Patient's Relationship to Subscriber:	Self $\square$	Spouse		Child		Other:					
AUTO OR WORK INJURY CLA	AIM	(PLEAS	E PRO	OVIDE	YO	UR INSURA	NCE	INFO	RMATIO	N FOR	BACKUP)
Insurance Name:   Auto:			Labo	r & Ind	dustr	ies:					
Adjuster/Claim Manager:						Phone	:			_	Ext.:
Address: Cir			City				State: Zip:			•	
Claim #:	Accide	ent Date:	/	/ /	′	(	Cause	e:			
ATTORNEY INFORMATION											
Name:		Law Fire	m:				P	hone: (	( )		
Address City					State: Zip:				:		
IN CASE OF EMERGENCY											
Name of Local Friend or Relative (Not	Living at Sa	ame Addre	ess):								
Relationship to Patient:	Home	e Phone: (	)	-		7	Work	Phone	e: ( )	-	

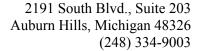
I authorize my insurance benefits be paid directly to StayFIT Rehab. I understand that I am financially responsible for any balance. I also authorize StayFIT Rehab to release any information required to process my claims.





## PAST MEDICAL HISTORY FORM Patient Name

Hyper Extremity   Dislocation   Dislocatio	BLOOD PRESSURE	YES	NO	JOINT CONDITIONS	YES	NO			
Low Blood Pressure			Ĭ		П	Π			
Lower Extremity Dislocation		Ħ	Ħ		Ħ	Ħ l			
HEART DISEASE YES NO Heart Attack Atherosclerotic Disease Myocardial Infarction Muscular Dystrophy Rheumatic Heart Disease Myocardial Infarction Multiple Sclerosis M		Ħ	$\Box$		Ī				
Heart Atlack Alterosclerotic Disease Myocardial Infarction Myocardial Infarction Myocardial Infarction Myocardial Infarction Multiple Sclerosis Epilepsy Do you have a pacemaker Do you have a pacemak		_	<del>_</del>	,	<del></del>				
Alterosclerotic Disease	HEART DISEASE	YES	NO	OTHER CONDITIONS	YES	NO			
Myocardial Infarction	Heart Attack			Muscular Dystrophy					
Rheumatic Heart Disease	Atherosclerotic Disease			Rheumatoid Arthritis					
Heart Murmur	Myocardial Infarction			Multiple Sclerosis					
Do you have a pacemaker				Epilepsy					
MUSCLE CONDITION VES NO Diabetes									
Carpal Tunnel R/L									
Tenis Elbow R/I.		YES	NO						
Back/Neck Problems									
LUNGS YES NO Asthma		$\sqcup$							
Asthma		$\sqcup$							
LUNGS YES NO  Ashtma	Limited Limb Movement	Ш							
Asthma		*****	210	Other:					
EXERCISE   WORK ACTIVITY   STRESS LEVEL   HABITS     None		YES	NO						
Shortness of Breath		$\vdash$	$\vdash$						
EXERCISE		H	H						
None Sitting Low Smoking Packs a Day   □ 1-2 x Week Standing Medium Alcohol Drinks a Week   □ 3-4 x Week Light Labor High Coffee/Soda Cups a Week    What types of exercise do you perform?:  What things cause stress in your life?:  Are you taking any seizure medication?	Shortness of Breath								
None Sitting Low Smoking Packs a Day   □ 1-2 x Week Standing Medium Alcohol Drinks a Week   □ 3-4 x Week Light Labor High Coffee/Soda Cups a Week    What types of exercise do you perform?:  What things cause stress in your life?:  Are you taking any seizure medication?									
1-2 x Week		TIVITY							
3.4 x Week									
S+ x Week □Heavy Labor   What types of exercise do you perform?: What things cause stress in your life?: Are you taking any seizure medication? □YES □NO If yes list name: □YES □NO If yes list name: □List all medications you are currently taking: □List all surgeries in the past two years (Including dates): □Are you pregnant? □YES □NO What week? □Have you had any injuries related to work? □YES □NO If yes list body part and date.: □Have you had any auto accidents? □YES □NO If yes list body part and date.: □Have you had any auto accidents? □YES □NO If yes list body part and date.: □NO □YES □NO □NO □YES □NO □NO □YES □NO □NO □YES □NO </td <td></td> <td></td> <td>☐ Mediı</td> <td><del></del></td> <td>Drinks a W</td> <td>/eek</td>			☐ Mediı	<del></del>	Drinks a W	/eek			
What types of exercise do you perform?:  What things cause stress in your life?:  Are you taking any seizure medication?			High	☐ Coffee/Soda	Cups a We	ek			
Are you taking any seizure medication?	☐ 5+ x Week ☐ Heavy Lab	or							
Are you taking any seizure medication?	***	0							
Are you taking any seizure medication?		? :				_			
Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?    YES	What things cause stress in your life?:								
Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?    YES									
Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?    YES	Are you taking any seizure medication	? <b>П</b> Ү	ES 🗆 NO	If ves list name:					
□YES □NO If yes list name:   List all medications you are currently taking:									
List all medications you are currently taking:  List all surgeries in the past two years (Including dates):  Are you pregnant?	Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?								
List all medications you are currently taking:  List all surgeries in the past two years (Including dates):  Are you pregnant?									
List all surgeries in the past two years (Including dates):  Are you pregnant?	☐YES ☐NO If yes list name:								
List all surgeries in the past two years (Including dates):  Are you pregnant?									
List all surgeries in the past two years (Including dates):  Are you pregnant?	List all medications you are currently taking:								
List all surgeries in the past two years (Including dates):  Are you pregnant?									
Are you pregnant?									
Are you pregnant?	List all surgeries in the past two years (	Including da	tes):						
Have you had any injuries related to work?			, <u> </u>						
Have you had any injuries related to work?									
Have you had any injuries related to work?	Are you pregnant?  YES NO What week?								
Have you had any auto accidents?									
Have you had any auto accidents?	Have you had any injuries related to work? YES NO If yes list body part and date.:								
	, , ,								
	Have you had any auto accidents?	☐ YES	□ NO If	yes list body part and date.:					
Have you had Physical Therapy or Massage Therapy before?									
Trave you had I mysical Therapy of Massage Therapy October 1100 1100 willete.	Have you had Physical Therapy or May	ssage Theran	v hefore?	VES NO Where:					
	Trave you had I hysical Therapy of Mas	souge incrap	, octore:	125 LITO WHOLE.					

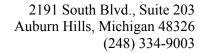




## PAST MEDICAL HISTORY FORM Patient Name

BLOOD PRESSURE	YES	NO	JOINT CONDITIONS	YES	NO		
Hypertension			Upper Extremity				
Low Blood Pressure	Ħ	Ħ	Dislocation	Ħ	Ħ I		
Normal Blood Pressure	Ī	Ī	Lower Extremity Dislocation	Ħ			
	_	<del></del>	,	_			
HEART DISEASE	YES	NO	OTHER CONDITIONS	YES	NO		
Heart Attack			Muscular Dystrophy				
Atherosclerotic Disease			Rheumatoid Arthritis				
Myocardial Infarction			Multiple Sclerosis				
Rheumatic Heart Disease	Ц	Ц	Epilepsy		Ц		
Heart Murmur			Gout		Ц		
Do you have a pacemaker			Fibromyalgia				
MUSCLE CONDITION	YES	NO	Diabetes	$\vdash$	닏		
Carpal Tunnel R/L	님	닏	Hearing Loss	님	닏		
Tennis Elbow R/L	님		Poor Eyesight	님			
Back/Neck Problems	님	H	Fainting	H	H		
Limited Limb Movement	Ш	Ш	Polio				
LUNGS	YES	NO	Other:				
Asthma	TES	NO	-		<u> </u>		
Emphysema	H	H					
Shortness of Breath	H	H					
Shortness of Breath							
		6 mm n 6		***			
EXERCISE WORK AC	TIVITY		S LEVEL	HABITS			
None Sitting		Low	Smoking	Packs a Da			
1-2 x Week Standing		Medium		Drinks a W			
3-4 x Week Light Labo		☐ High	Coffee/Soda	Cups a We	ek		
5+ x Week Heavy Labo	or						
What types of average do you perform	n .						
What types of exercise do you perform What things cause stress in your life? :	·				<u> </u>		
what things cause stress in your me!.							
Are you taking any seizure medication?	? □YE	S 🔲 NO	If yes list name:				
Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?							
☐YES ☐NO If yes list name:							
T : . 11 1: .:							
List all medications you are currently							
taking:	-						
List all surgeries in the past two years (	Including date	s):					
Are you	What						
pregnant?							
- — —		-					
Have you had any injuries related to	ork? DVEC		was list hady part and data.				
Have you had any injuries related to wo	лк: Ц тЕз	o ∟ NU II	yes list body part and date.:				
		_					
Have you had any Auto Accidents	☐ YES	☐ NO If ye	s list body part and date.:				
Have you had Physical Therapy or Mas	ssage Therany	before?  \[ \subseteq \ \text{Y}	ES NO Where:				
j j	(۳۳						

	~ .	C								
ain and S	Sympto	om Status R	eport							
Vame						Date				
-	y outline	below, please oes, the type of p		ation						
Ach MMN MN	1M	Burning	Numbnes				1	Right		
Pins & N		Stabbing	Other		JAJA (		THE STATE OF THE S		el <sub>u</sub>	
		//////////////////////////////////////	XXXX		Right \		Left		Left	Right
							) •		Left	
Chief Com	ıplain	t and Visual	l Analog Sc	ale						
Лу Chief Cor	nplaint	is:								
Oate First Syr	nptom c	of Your Problen	n Occurred on:							
e <sup>nd</sup> Complaint	t:									
		Please circle o	n the scale be	low to	indicate	your <u>C</u>	URREN	T leve	of pai	in:
No Pain	0	1 2	3 4	5	6	7	8	9	10	Pain as bad as it gets
		Please circle o	n the scale be	low to	indicate	your <u>A</u>	VERAG	E leve	of pai	in:
No Pain	0	1 2	3 4	5	6	7	8	9	10	Pain as bad as it gets
		Please circle	on the scale b	elow t	o indicat	e your	WORST	level o	of pain	:
No Pain	0	1 2	3 4	5	6	7	8	9	10	Pain as bad as it gets
Additional Co	omments	S:								





## CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as <u>StayFIT Rehab</u> or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

## **SIGNATURE**

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

Name of Patient (Print Clearly)	
Signature of Patient	Date
Signature of Patient Representative	
Relationship of Patient Representative to Patient	