ACTION PHYSICAL MEDICINE AND REHABILITATION

Patient Information Sheet

Personal Information

Name:________________________________ Date of Birth: _______________ Sex: _______ Initial Office Visit Date: _____________

Mailing Address:____ Social Security #: ______________________________

____ Ethnicity: ______________________________

City State Zip Code Work #: ______________________________

Home Telephone #: ______________________________ Cell #: ______________________________

E-mail Address: ______________________________ Primary Language: ______________________________

Contact Preference: Home Work Cell E-mail Do you have a living will? Yes No

How did you hear about us? ____

Referring Physician Name, Address, & Telephone #: ____

____

Primary Care Physician Name, Address, & Telephone #: ____

____

Name of Employer: ____ (Self Employed: Yes No)

Employer's Address & Telephone #: ____

Emergency Contact: ____ Emergency Telephone #: ______________________

Insurance Information

Primary Insurance

Name of Person Insured: ____ Insured's Date of Birth: ______________________

Insured Social Security #: ____ Employer's Name: ______________________

Name of Insurance Company & Address: ____

Telephone #: ___________________________ Policy/ID #: _________________________ Group/Account #: ___________________

Secondary Insurance

Name of Person Insured: ____ Insured's Date of Birth: ______________________

Insured Social Security #: ____ Employer's Name: ______________________

Name of Insurance Company & Address: ____

Telephone #: ___________________________ Policy/ID #: _________________________ Group/Account #: ___________________

Workers Compensation Information --- Is this Workers Compensation? Yes No

Date of Injury: _____________________ Claim #: ___________________________________

Workers Compensation Name, Address, & Telephone #: ____

____

Auto Accident Information --- Is this from an Auto Accident? Yes No

Date of Injury: _____________________ Claim #: ___________________________________

Auto Insurance company Name, Address, & Telephone #: ____

____

Release of Information

I hereby authorize any treatment deemed necessary by Action Physical Medicine and Rehabilitation. I also authorize the release of any information necessary to process my claim.

____ ________________

Signature of Insured / Authorized person Date

Assignment of Benefits

I authorize payment of benefits to Action Physical Medicine and Rehabilitation for ALL services rendered. I understand that I may be responsible for any balance NOT covered by my insurance company.

____ ________________

Signature of Insured / Authorized person Date

Account Balance Policy

If I have an outstanding balance of more than $100.00 on my account at the time of my appointment, I agree to pay at least $25 per week towards my account balance in addition to other fees I have already accepted, until the balance is below $100.00. If I am unable to make this payment, I understand my appointment may be cancelled or rescheduled until I am able to do so.

____ ________________

Signature of Insured / Authorized person Date

ACTION PHYSICAL MEDICINE AND REHABILITATION

Patient History

Please fill out this form to the best of your knowledge

Patient Information

Patient Name: ____ Age:____________ Date:_______________________________

Date of Birth: _________________ Sex: ________ Height: ___________ Weight: __________ Right/Left Handed:_____________

Primary Care Physician: ____ Phone #: ___________________________________

Referring Physician: ____ Phone #: ___________________________________

Reason for Evaluation (please describe in detail your illness/injury): ____

____

____

____

____

____

____

____

Date when illness/injury began: ___________________

Review of Systems **Please circle or check all that apply**

Heart:

Chest Pain | Irregular Heart Rate | Phlebitis | Bypass Surgery | Coronary Artery Disease

Palpitations | Valve Replacement | Cellulitis | Catheterization | Other: _________________

Heart Failure | Hypertension | Lymphedema | Angioplasty | _______________________

Pacemaker | Hypercholesterol | Stent Placement

Lungs:

Emphysema | Shortness of Breath | Pneumonia | Asthma | Pulmonary Embolism

Other: _____________________________________

Gastrointestinal:

Reflux Disease | Hiatal Hernia | Hemorrhoids | Abdominal Aortic Aneurysm

Gallstones | Gallbladder Removal | Appendectomy | Colon Resection | Hepatitis

Bowel Incontinence | Other: _____________________________________

Genitourinary:

Enlarged Prostate | Indwelling Catheter | Kidney Stones | Frequent Urinary Tract Infections

Hysterectomy | Bladder Incontinence | Prostate Surgery | Other: ___________________________________

Musculoskeletal:

Fractures | Osteoarthritis | Neck Pain | Rheumatoid Arthritis | Osteoporosis

Low Back Pain | Scoliosis | Disc Disease | Other: ___________________________________

Endocrine:

Diabetes | Hypothyroid | Other: _________________

Mental Health:

Depression | Anxiety | Bipolar Disorder | Panic Attacks | Schizophrenia

Other: _____________________________________

Cancer:

Location: ____

Surgery: ____

Chemotherapy: Yes No Duration: _____________________________________

Radiation: Yes No Duration: _____________________________________

Do you need **HELP** with any of the following? (please circle **ALL** that apply):

Grooming	Getting in/out of bed	Feeding
Upper body dressing	Getting in/out of chairs	Toileting
Lower body dressing	Getting in/out of tub or shower	Bathing

Do you have any of the following symptoms? (please circle **ALL** that apply):

Weight Loss	Chest Pain	Balance	Fever	Swelling
Blurred Vision	Chills	Numbness/Tingling	Headaches	Nausea
Incontinence	Weakness	Vomiting	Insomnia	Memory
Diarrhea	Sexual Function	Tremors/Shaking	Constipation	Walking
Muscle Spasms	Dizziness	Shortness of Breath	Swallowing	

Medication (please list **ALL** medication and directions)

____
____
____
____
____
____
____

Pharmacy Name, Address, & Telephone #: ______________________________
____

Medication Allergies: ______________________________
____

Other Allergies: ______________________________

****Our medication refill number is (815) 725-9707. Please note there is a 5 business day notice for all refill requests.****

Past Medical History (Please list any surgery or test)

Surgery (type and date): ______________________________
____
____

Test (MRI, CT scan, EMG, etc…….) (type and date): ______________________________
____
____
____
____
____

Social History

Work

Occupation: ______________________________

Date last worked: ______________________________

Living accommodations (house, apartment, nursing home, etc…….): ______________________________

Patient lives with: ______________________________

Do you require assistive devices? Yes No

Type (circle **ALL** that apply): Cane Crutches Walker Wheelchair Braces Splints

Do you smoke current? Yes No

Packs per day: __________

Did you smoke previously? Yes No

Do you drink alcohol? Yes No

How much per week: __________

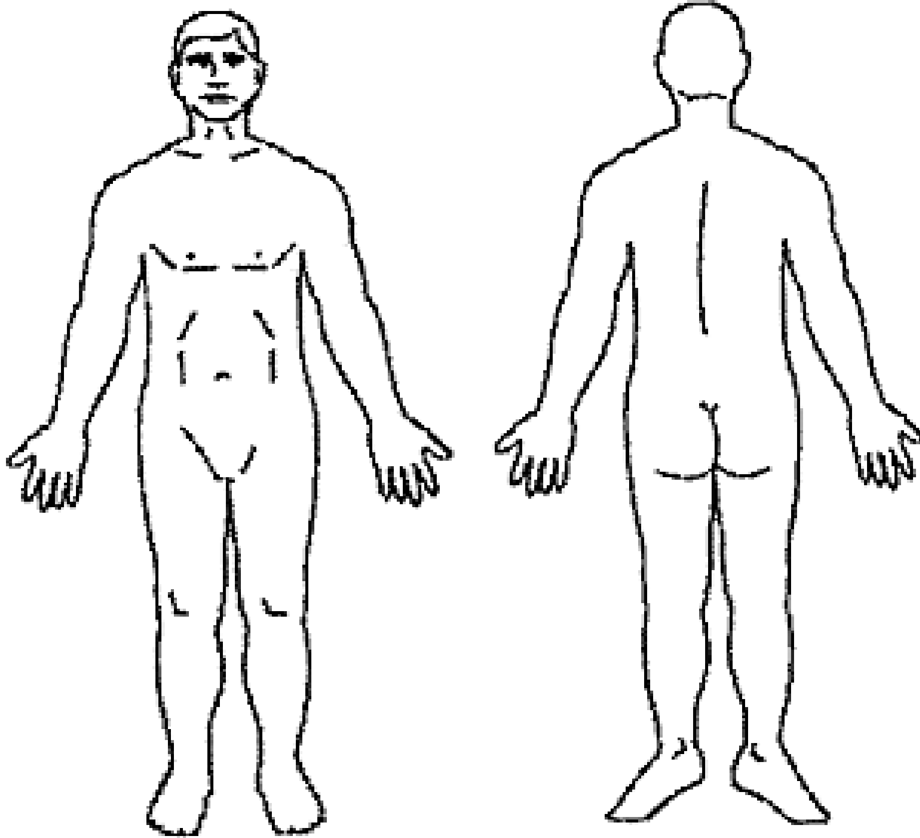
Do you use recreational drugs? Yes No

Please mark on the diagram below where your pain occurs

Dull Pain – "+" Numbness – "N"

Burning Pain – "B" Pins/Needles – "X"

Sharp/Stabbing Pain – "S" Other/Describe – "/"



What is the current level of your pain? Mark on line with an X

None 0 1 2 3 4 5 6 7 8 9 10 Severe

ACTION PHYSICAL MEDICINE AND REHABILITATION

Cancellation and No Show Policy

850 Brookforest Ave, Unit F.
Shorewood, Illinois 60404
Phone # 815 725 4918
Fax # 815 725 4955

2156 Deepwater Lane, Suite 108
Naperville, Illinois 60564
Phone # 630 904 5640
Fax # 630 904 5661

Attendance in our Pain Management and Physical Therapy program is required in order for your recovery and rehabilitation to be effective. We take great pride in returning patients back to their pre-injury lifestyles quickly and effectively. Our success has been directly linked to our patient's compliance with attendance, therefore we have developed this policy:

- If a patient cancels/no shows (3) times during the treatment process, he/she may be discharged/released from care.
- The rescheduling of cancelled appointments are NOT included in the (3) times
- If a patient is under Worker's Compensation, the case manager will be notified for each cancel.
- No shows can be assessed the following charge:
  - No show for schedule procedure $50.00
  - No show for established patient $35.00
  - No show for new patient $50.00
- Patients that arrive more than 15 minutes past their scheduled visit WITHOUT calling to notify may be assessed a $25 no show charge, and may need to be re-scheduled.

Please be prompt for all scheduled visits. Action prides itself on the effectiveness of one-on-one care. Patients that arrive late for scheduled visits affect the one-on-one care of themselves and others.

Thank You!

Patient Name (please print)	Patient Signature	Date
Employee Name (please print)	Employee Signature	Date

ACTION PHYSICAL MEDICINE AND REHABILITATION

Acknowledgement of Receipt of Notice of Privacy Practices

850 Brookforest Ave, Unit F.
Shorewood, Illinois 60404
Phone # 815 725 4918
Fax # 815 725 4955

2156 Deepwater Lane, Suite 108
Naperville, Illinois 60564
Phone # 630 904 5640
Fax # 630 904 5661

Please print, sign, and date your name that Notice of Privacy Practices form was received.

____
Patient or Legal Representative, Name (please print)

____
Patient or Legal Representative, Signature

____
Date

*****All patients will be required to provide a urine sample at their first visit, as well as on a yearly basis.*****
*****PHOTOS MAY BE TAKEN FOR INTERNAL USE*****

Acknowledgement <u>NOT</u> obtained because:

__ Patient of Legal Representative declined Notice of Patient Privacy Practices
__ Patient incompetent
__ Patient unable to sign
__ Other (describe briefly) ____
____

____
Employee Name (please print)

____
Employee Signature

____
Date