

PATIENT INFORMATION



Patient Last name First name Middle initial Home phone number Cell Phone number

Street address City State Zip

Date of birth Age Sex Social Security Number Marital status

Employer's name Employer's phone

Referring doctor Referring doctor number Attorney name Attorney's number

Who referred you to our office? Name of primary care physician Primary care physician number

SPOUSE/ PARENT (IF NOT MARRIED) INFORMATION

Last name First name Initial Date of birth

Their Employer's name Employer's phone

WHO CAN WE CALL IN CASE OF AN EMERGENCY

Their name Relation to patient Phone number

Their address City State Zip

INSURANCE INFORMATION: Is my referral due to a Workers Comp or Personal Injury? Yes No Circle one

Please present your insurance card to the receptionist when you hand in your paper work. Thank you.

Primary insurance company name Policy number Group number

Primary insurance address City State Zip

Policy holder's name (from card) Social Security Number Date of birth

Secondary insurance company name Policy number Group number

Secondary insurance address City State Zip

Policy holder's name (from card) Social Security Number Date of birth

RESPONSIBILITY STATEMENT & RELEASE OF INFORMATION

I understand that I am responsible for paying for all medical services not covered by an authorization/agreement between Physical Rehabilitation Center of Tulsa and my insurance carrier or attorney. I authorize the release of any or all of the patient's medical records for this period of care to any person/corporation liable for any part of the physician charges and the patient's attorney. Oklahoma state law requires that we advise "The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS)."

Patient or Legal Guardian Signature Date

Patient Health Questionnaire

Name: _____ Date: _____

Occupation/Employer: _____

Job Duties: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Past surgical procedures: _____

List medications and reasons for taking: _____

Check if you have had a ___ MRI, ___ CT Scan, ___ Bone Scan or ___ X-Rays of your related injury?

If you have had a MRI, specify what region of body, approximate date, MRI facility and doctor who ordered:

Check if you have or have you ever had any of the following conditions:

- _____ Abdominal Aneurysm _____ Pacemaker
- _____ Diabetes _____ Hepatitis A B C (please circle one)
- _____ High Blood Pressure _____ HIV (+)
- _____ Heart Attack, Stroke _____ TB
- _____ Rheumatoid Arthritis, Lupus, Scleroderma, or other connective tissue disorder
- _____ Are you currently or are you planning to be pregnant during treatment?
- _____ Cancer, and list type and treatment received or in remission

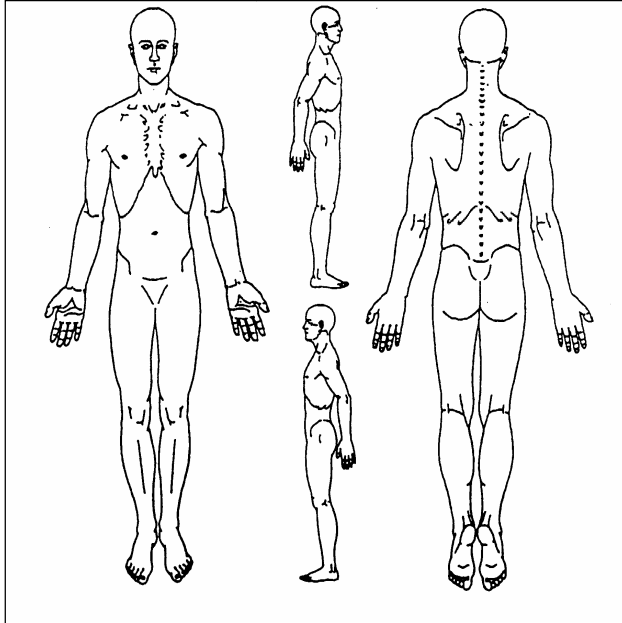
Other pertinent conditions: _____

1) Please describe your symptoms: _____

2) Date of injury or onset of symptoms: _____

3) How injury occurred _____

4) On the chart below please mark the location of your symptoms.



X = Pain

||| = Numbness / Tingling

+ = Swelling

5) Please rate your pain on a scale of 1-10 with one (1) being the least and ten (10) being the worst.

Upon injury or onset of pain: 1 2 3 4 5 6 7 8 9 10

Worst pain over the last 2 weeks: 1 2 3 4 5 6 7 8 9 10

6) Have you required medical attention for this problem in the past? Yes No

If yes, please explain: _____

7) Please list any factors that increase your symptoms: _____

8) Please list any factors that decrease you symptoms: _____