

## Patient Registration Form

First Name \_\_\_\_\_ MI \_\_\_ Last Name \_\_\_\_\_ Title \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Gender  Male  Female

Mailing Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physical Address \_\_\_\_\_

\_\_\_\_\_

Driver's Lic # \_\_\_\_\_

	OK To Call	Best Time To Call
Home Phone _____	<input type="checkbox"/>	_____
Work Phone _____	<input type="checkbox"/>	_____
Cell Phone _____	<input type="checkbox"/>	_____

Marital Status	<input type="checkbox"/> Single	Employment Status	<input type="checkbox"/> Full-Time	<input type="checkbox"/> None
	<input type="checkbox"/> Married		<input type="checkbox"/> Part-Time	<input type="checkbox"/> Student
	<input type="checkbox"/> Separated		<input type="checkbox"/> Self Employed	<input type="checkbox"/> Retired
	<input type="checkbox"/> Divorced		<input type="checkbox"/> Active Duty	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Widowed		<input type="checkbox"/> Disabled	
	<input type="checkbox"/> Unknown			

Email Address \_\_\_\_\_ Interpreter Required?  Language \_\_\_\_\_

Patient Employer \_\_\_\_\_ Spouses Employer \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Occupation \_\_\_\_\_

**How did you hear about us?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Physician      | <input type="checkbox"/> Hospital               | <input type="checkbox"/> Marketing Ad - Print               |
| <input type="checkbox"/> Employer       | <input type="checkbox"/> Cross Referral         | <input type="checkbox"/> Marketing Ad - TV                  |
| <input type="checkbox"/> Case Manager   | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard           |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney               | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor       | <input type="checkbox"/> Self                   |   |
| <input type="checkbox"/> School         | <input type="checkbox"/> Screens - Open Houses  |   |

Specify: \_\_\_\_\_

Re:

Attorney Name \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Prescribing MD \_\_\_\_\_

Phone \_\_\_\_\_

Do you have a written prescription?  Yes  No

Next MD Visit \_\_\_\_\_

Body Part / Region \_\_\_\_\_

Date of Injury \_\_\_\_\_

Was this injury the result of an accident?  Work  Auto  Other  None

Do you wish to receive social services?  Yes  No

#### AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any and all information to my insurance company or other appropriate party, as required, pertaining to treatment rendered to me by Heartland Rehabilitation Services. Further, I authorize Heartland Rehabilitation Services to obtain needed information from my physician, employer or insurance company.

#### CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY

I hereby consent to the treatment as prescribed by my physician and provided by Heartland Rehabilitation Services, its employees, or representative. I understand that I am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill.

#### NOTICE OF INFORMATION PRACTICES

I acknowledge that I have been shown the posted Notice of Information Practices by Heartland Rehabilitation Services

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

# MEDICAL HISTORY FORM

Patient Name: \_\_\_\_\_

Area of Symptoms: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Onset: \_\_\_\_\_

Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures for their effectiveness and your safety. Thank you.

Any known results of recent x-rays or tests: \_\_\_\_\_

Chronic Conditions: Yes  No  If yes, please list: \_\_\_\_\_

Allergies: Yes  No  If yes, please list: \_\_\_\_\_

List surgeries and dates: \_\_\_\_\_

Medications: Yes  No  If yes, please list: \_\_\_\_\_

Do you have or have you had any of the following:

Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Metal Implants	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy or Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Respiratory Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

1. How would you rate your ability to perform routine daily activities:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%  
Unable to perform No Problems

2. How would you rate your ability to perform the activities associated with you job:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%  
Unable to perform No Problems

3. How would you rate your current pain:

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

4. How many days since your current injury?  0-30 days  31-90 days  90+ days

Please draw your pain on the body to the right using the following symbols:

/// Stabbing pain  
xxx Burning  
ooo Pins and needles  
=== Numbness

