LAFAYETTE Rehabilitation Services

A UNITY HEALTHCARE PARTNER

Name: _____ **I prefer to be called:** _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: Home: _____ **Work:** _____ **Cell:** _____

Email address: _____ **Gender:** ☐M ☐F **Hand Dominance:** ☐R ☐L

Emergency Contact: _____ **Relationship:** _____ **Phone Number:** _____

Have you been a patient here before? ☐Y ☐N **If yes, for** ☐ the same or ☐ a different problem?

How did you hear about us? ☐Physician ☐Friend/Family Member ☐Other: _____

Primary Care Physician: _____ Therapy evaluations will be copied to your PCP (☐Do not send)

Have you had any other therapy this calendar year? ☐Y ☐N (circle) Physical Occupational Speech

For what body region(s) are you seeking treatment? (please circle) Neck Mid-Back Lower Back Shoulder Elbow Hand/Wrist Hip Knee Ankle/Foot Other: _____

When did your symptoms start? _____ **Can you identify a cause for your symptoms:** ☐Y ☐N

If related to an injury, what kind? (please circle) Auto Work Athletic Liability Other: _____

Have you retained an attorney as a result of this injury? ☐Y ☐N

If this is a work injury, employer name: _____

Have you had surgery related to this diagnosis? ☐Y ☐N **If yes, when?** _____

Have you had any of the following tests for this problem? X-rays CT Scan MRI Bone Scan EMG/NCV Blood Test Stress Test EKG Bone Density Test Other: _____

Circle your *AVERAGE* level of pain: 0 (No pain) 1 2 3 4 5 6 7 8 9 10 (Emergency Room)

Describe your pain (circle all that apply): intermittent frequent constant sharp dull achy burning throbbing shooting tender tightness numb tingling other: _____

Does your pain move/radiate anywhere? ☐Y ☐N **If yes, where?** _____

Is your pain getting (please circle one): better worse staying the same

Have you had any changes in your bowel/bladder/sexual function due to these symptoms? ☐Y ☐N

What makes the pain worse? (circle all that apply) sitting standing walking reaching bending lifting looking up breathing deeply repetitive motions squatting stairs other: _____

What makes the pain better? (circle all that apply) medicine ice heat rest changing positions

Does your pain prevent you from sleeping? ☐Y ☐N **Can you lie on the affected side?** ☐Y ☐N

Have you had any treatment in the past for this problem? Physical Therapy Medication Injections Pain Management Chiropractic Massage Tens Unit Acupuncture **Did it help?** ☐Y ☐N

Have you ever had an allergic reaction to: Latex Band-Aids Cortizone Gel Lotion Beeswax

Have you fallen in the last year? ☐Y ☐N **How many times?** _____ **Did you get hurt?** ☐Y ☐N

Do you live alone? ☐Y ☐N **Do you have a friend/family member to help you if needed?** ☐Y ☐N

Do you smoke/use tobacco products? ☐Y ☐N **Is there a chance you could be pregnant?** ☐Y ☐N

During the past month, have you been feeling down, depressed, or hopeless? ☐Y ☐N

LAFAYETTE Rehabilitation Services

A UNITY HEALTHCARE PARTNER

Do you ever feel unsafe at home, or has anyone hit you or tried to injure you in any way? ☐Y ☐N

Please list all medications you are currently taking, including prescription, over-the-counter, & supplements:

Use back of this page if necessary. If you have a written list with you, our receptionist can make a copy for you.

Medication Name	Dosage/Frequency	Reason for Taking

Please list any relevant surgeries, including when they were performed (month and/or year):

_____

_____

Is your general health (please circle one): Excellent Good Fair Poor Very Poor

What other medical problems do you or have you had?

☐High Blood Pressure	☐Diabetes	☐Kidney Failure	☐Stroke	☐Thyroid Problems
☐Depression/Anxiety	☐Cancer	☐Stomach Ulcers	☐Heart Disease	☐Lung Problems
☐Bleeding Tendency	☐Asthma	☐HIV/AIDS	☐Heart Attack	☐Blood Clots
☐Osteopenia/Osteoporosis	☐Epilepsy	☐ Rheumatoid Arthritis	☐Gout	☐Pacemaker

What other symptoms do you have?

☐Chest Pain/Pressure	☐Palpitations	☐Shortness of Breath	☐Headaches
☐Frequent Urination	☐Rash	☐Itching	☐Dizzy Spells
☐Burning with Urination	☐Wheezing	☐Hearing Loss	☐Vision Loss
☐Unintentional weight loss	☐Swollen Glands	☐Heartburn/Reflux	☐GI Bleeding
☐Unintentional weight gain	☐Easy Bruising	☐Chills	☐Fatigue

AUTHORIZATION STATEMENT

I authorize and consent to treatment at Lafayette Rehabilitation Services (LRS).

I authorize release of my medical records to my physician, insurance company, employer, rehab nurse, and any other party that may have an interest in payment of my rehabilitation.

I acknowledge that I have access to a copy of LRS's notice of privacy practices that describes my rights and LRS's duties with respect to my protected health information.

Patient Signature: _____ Date: _____

Guarantor's Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

1411 S. Creasy Lane, Suite 100 | Lafayette, IN 47905 | Phone: 765.447.5552 | Fax: 765.449.1054
3451 Wyndham Way, Suite D | West Lafayette, IN 47906 | Phone: 765.446.5250 | Fax: 765.446.5208
www.lafayetterehabilitation.com