INTEGRATED REHABILITATION GROUP
Physical and Hand Therapy Services
WWW.IRGPT.COM

Patient Intake Form

Patient Information

First Name _____ **MI** ___ **Last Name** _____ **DOB** ____/____/_____

Address _____ **Apt#**_____ **City** _____ **State** _____ **Zip** _____

Cell Phone (_____) _____-_____ **Alternate Phone** (_____) _____-_____ ☐ **Male** ☐ **Female**

Permission to Text Appointment Reminders: ☐ **Y** ☐ **N** **Social Security #** _____-_____-_____

☐ **I hereby give permission for IRG &/or Affiliates to leave a detailed message on my voicemail/answering machine.**

Email Address: _____

☐ **I hereby give permission for IRG, Inc. & Affiliates to send me email messages.**

How did you hear about us? ☐ **Health Care Provider** ☐ **Friend/Relative** ☐ **Website** ☐ **Other:** _____

Parent Name_____ **Address** _____ **Phone** (____) ____-_____
(If patient is a minor) (If different than above)

Emergency Contact

Name: _____ **Relationship** _____ **Phone** (_____) _____-_____

Problem

Injury/Body Part(s) _____ **Date of Surgery** ___/___/_____

Referring Provider _____ **Primary Care Physician** _____ **Last MD Visit** ___/___/___

Medical Insurance Information

Primary Insurance: _____ **Secondary Insurance:** _____

Claim Information (If Applicable)

☐ **L&I Claim** ☐ **Worker's Comp/Self-Ins Claim** **Date of Injury** ___/___/____

Employer: _____

Claim Manager's Name: _____ **Phone** (_____) _____-_____ **Ext**_____

☐ **Motor Vehicle Accident** **Date of Accident** _____/___/_____ **State Accident Occurred:** _____

Your Car Insurance Company: _____ **Available P.I.P?** ☐**Y** ☐**N**

Adjuster's Name: _____ **Phone** (_____) _____-_____ **Ext**_____

IRG & Affiliates HIPAA Privacy Check all that apply

View HIPAA Notice

☐ **I acknowledge receipt of a copy of the Notice of Privacy Practices**

☐ **I have been offered a copy of the Notice of Privacy Practices, but I have chosen to decline a copy at this time**

☐ **I hereby give permission for IRG & Affiliates to discuss my medical information with:** _____

Consent for Treatment, Assignment of Benefits, & Release of Information: I hereby authorize you to evaluate & treat me (or my dependent) and I assign directly to Integrated Rehabilitation Group, Inc. & LLC Affiliates all medical insurance benefits, if any, for services rendered.

I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original.

Signature _____ **Date** _____
(Parent or Guardian if patient is a minor)

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MEDICAL QUESTIONNAIRE

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

What is the reason for your visit today? _____

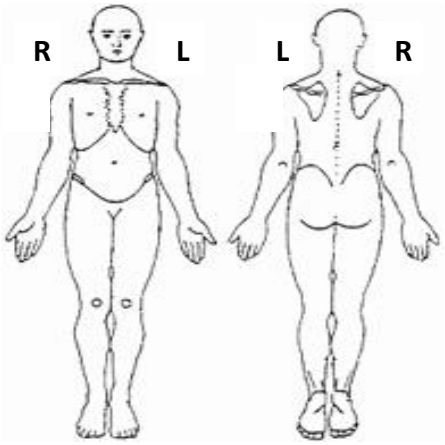
Employer: _____ **Occupation:** _____ **Hrs/Wk:** _____

Date of Injury: _____ **Date of Surgery (if applicable):** _____ **Side of Injury:** ☐ R ☐ L ☐ Bilateral

Where did your injury occur? ☐ Work ☐ Auto/MVA ☐ Home ☐ Gradual Onset ☐ Other: _____

Describe how your condition or injury occurred: _____

Briefly describe your symptoms: _____



Shade your areas of pain or discomfort on the figures to the left *(after printing document)*

Please rate your pain on the scale below from 0 to 10: (0 =no pain; 10 = worst pain imaginable)

Pain at rest: ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Pain with activity: ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

What is the frequency of your pain? ☐ Constant ☐ Intermittent

Does your pain wake you at night? ☐ Y ☐ N **How many times?** _____

Are your symptoms getting: ☐ Better ☐ Worse ☐ Staying the same

When is your pain the worst: ☐ Morning ☐ Night ☐ Mid-Day

What eases your symptoms? _____

What aggravates your symptoms? _____

What activities at home, work or recreational are you unable to perform? _____

Have you had a similar condition before? ☐ Y ☐ N **If yes, when** _____

Have you had any of the following treatment and/or tests for this condition? (check all that apply)

❑ Physical Therapy ❑ Occupational Therapy ❑ Chiropractic ❑ Massage ❑ Hospitalization ❑ Home Health ❑ Acupuncture
❑ X-Rays ❑ MRI ❑ CT Scan ❑ Bone Scan ❑ Nerve Tests ❑ Bracing/Taping ❑ Other: _____

What do you hope to accomplish with Therapy? *(your personal goals)* _____

Medical History (Check all that apply)

❑ Allergies	❑ Chemical Dependency	❑ Fractures	❑ MRSA
List: _____	❑ Cancer	❑ Heart (Surgery, Attack, Disease)	❑ Multiple Sclerosis
❑ Anxiety	Type(s):_____	❑ Hepatitis	❑ Osteoporosis
❑ Asthma	❑ Depression	❑ High Blood Pressure	❑ Poor Circulation
❑ Arthritis	❑ Diabetes (Type I)	❑ High Cholesterol	❑ Seizures
❑ Blood Clots	❑ Diabetes (Type II)	❑ Hypoglycemia	❑ Sensitivity to heat/ice
❑ Bowel/Bladder Problems	❑ Dizziness/Vertigo	❑ Kidney Problems	❑ Stroke
❑ Bruise Easily	❑ Fibromyalgia	❑ Loss of balance/Falls	❑ Traumatic Injury

❑ Other: _____ ❑ No significant medical history

Other Relevant Medical Information

Height: _____ **Weight:** _____ **Do you have a pacemaker?** ☐ Y ☐ N **Do you have a latex allergy?** ☐ Y ☐ N

Do you smoke or chew tobacco: ☐ Y ☐ N **If yes, how much?** _____ **Are you pregnant?** ☐ Y ☐ N

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you exercise outside of normal daily activities? ☐ Y ☐ N **Type and frequency of activities:** _____

List any surgeries/major accidents/illnesses with dates: _____

List current medications: _____

SIGNATURE: _____ **DATE:** _____