Confidential Medical History/Evaluation

Kernersville Rehab Specialists, LLC
Physical and Occupational Therapy Center
Orthopedics • Spine and Sports Rehab • Pediatrics • Geriatrics

Name:_____Today's Date:_____/_____/_____

Address:_____City:_____State:_____Zip Code:_____

Date of Birth:_____/_____/_____Home Phone:_____Cell Phone:_____SS#_____

Referring MD: _____Facility:_____Phone: _____

E-Mail Address: _____

Emergency Contact Name:_____Relationship:_____Phone:_____

Sex: M F Marital Status: Single Married Divorced Other Are you currently receiving Home Health PT or OT?_____.

Insurance Company:_____Subscriber ID:_____Group #:_____

Are you employed? Yes No Occupation:_____ Are you ? Student Retired Unemployed .

Is this injury: Work Related Auto Accident Date of Onset **OR** Injury: _____/_____/_____

Condition: New Acute Chronic Chief Complaint: _____

Current Symptoms (circle what applies): Pain Numbness Stiffness Weakness Shooting
Dull Throbbing Sharp Aching Burning

List any/all medications you are currently taking:_____

Are you allergic to any medications?_____

Have you had surgery or injections for this injury/illness?: Yes No Number of Surgeries/injections: 1 2 3 4 ___

Type of Surgery:_____All other surgeries:_____

Have you had any of the following Medical or Rehabilitative services for this injury/episode?

	Yes	No		Yes	No
Chiropractor	___	___	CT Scan	___	___
EMG/NCV	___	___	General Practitioner	___	___
Massage Therapy	___	___	MRI	___	___
Myelogram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room Care	___	___	X-Rays	___	___

Other:_____

Do you now have or have you ever had ANY of the following? (Only mark if "yes")

	Yes		Yes
Asthma, Bronchitis, or Emphysema……..	___	Gout……..	___
Shortness of Breath/Chest Pain……	___	Sleeping Difficulties……..	___
Coronary Heart Disease or Angina……	___	Emotional/Psychological Problems……..	___
Do you have a Pacemaker…….	___	Bowel or Bladder Problems……..	___
High Blood Pressure……..	___	Severe/Frequent Headaches……...	___
Heart Attack/Surgery…….	___	Vision/Hearing Difficulties……	___
Stroke/TIA…….	___	Dizziness or Fainting……	___
Blood Clot/Emboli…….	___	Joint Replacement Surgery……	___
Epilepsy/Seizures……..	___	Neck Injury/Surgery……...	___
Thyroid Trouble/Goiter…….	___	Shoulder Injury/Surgery…….	___
Chronic Anemia…….	___	Elbow/Hand Injury/Surgery……...	___
Infectious Disease……..	___	Back Injury/Surgery……...	___
Diabetes…….	___	Knee Injury/Surgery……..	___
Cancer or Chemotherapy/Radiation……..	___	Leg/Ankle/Foot Injury/Surgery……	___
Arthritis/Swollen Joints…….	___	Numbness or Tingling?.....	___
Osteoporosis……...	___	Are You Pregnant?.....	___
Varicose Veins……..	___	Do you use Tobacco?.....	___

Other Medical Conditions:_____

_____

Are you aware of your Diagnosis? YES_____ NO_____ Are you aware of your Prognosis? YES_____ NO_____

DO YOU HAVE PAIN WHEN PERFORMING THE FOLLOWING ACTIVITIES?

	Mild	Severe	Unable
Bending	____	____	____
Care-Infirm Family	____	____	____
Lifting or Carrying	____	____	____
Change Positions (Sit to Stand)	____	____	____
Climbing Stairs	____	____	____
Driving a vehicle	____	____	____
Ability to use foot controls (accelerator or brake in vehicle)	____	____	____
Extended Computer Use	____	____	____
Drinking or Eating	____	____	____
Housework / Yard Work	____	____	____
Kneeling	____	____	____
Squatting	____	____	____
Lifting Children	____	____	____
Pet Care	____	____	____
Reading (Concentration)	____	____	____
Prolonged Sitting	____	____	____
Prolonged Standing	____	____	____
Self Care-Bathing	____	____	____
Self Care-Dressing	____	____	____
Self Care-Shaving	____	____	____
Sexual Activities	____	____	____
Job Activities	____	____	____

	Mild	Severe	Unable
Getting in and out of: □ chairs, □ bed, □ car □ bath or shower	____	____	____
Reaching / Lifting: □ overhead, □ behind back, □ downward □ forward	____	____	____
Maintaining static position of: □ head forward bent □ arms overhead □ arms forward □ turning head to check traffic	____	____	____
Walking on: □ flat surfaces □ inclines or uneven surfaces □ stairs or ladders	____	____	____
Sleeping through the night	____	____	____
Balancing on one or both feet	____	____	____
Picking up small objects	____	____	____
Gripping, holding tools, opening jars	____	____	____
Performing overhead activities	____	____	____
Running/Recreation/Sports	____	____	____
Hand Dominance	Right		Left
Other: _____			
_____			

Are your symptoms □ Constant □ Intermittent □ Getting Better
□ Getting Worse □ Staying the same

What makes your symptoms better? _____

What makes your symptoms worse? _____

Job requirements? _____

Maximum weight you lift at work? _____

Last date worked?___/___/___.

PAIN SCALE

10-The Most Extreme Pain, Call Emergency Services
9-Very, Very Strong Pain
8-Very Strong Pain
7-Strong Pain
6-Somewhat Strong Pain
5-Moderate Pain
4-Somewhat Moderate Pain
3-Light Pain
2-Very Light Pain
1-Minimal Pain
0-No pain at all

Worst Pain Rating _____

Best Pain Rating _____

Current Pain Rating _____

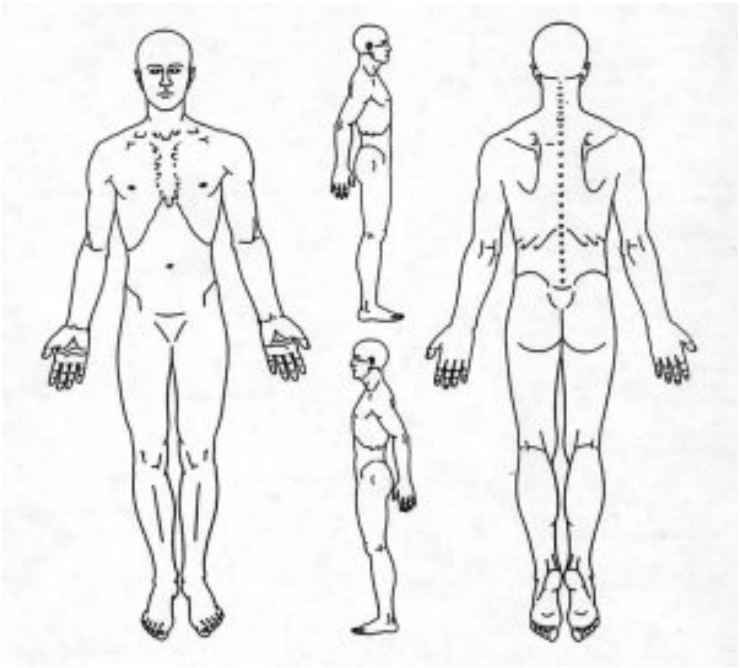
What do you want to accomplish with therapy (i.e. goal)? _____

_____

When is your next doctor visit?_____

Indicate on body diagrams **where** your symptoms are located.

Place a circle on the areas where you have pain:



I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Kernersville Rehab Specialists, regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature:_____ Date:_____

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature:_____ Date:_____

Kernersville Rehab Specialists

1031 E Mountain Street ◆ Bldg 318, Suite 101 ◆ Kernersville, NC 27284
336-996-4980 ◆ Fax: 336-996-3521

Notice of Patient Information Privacy Practices

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

Legal Duty

Kernersville Rehab Specialists, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Kernersville Rehab Specialists, LLC (hereafter known as KRS) uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, KRS may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

KRS may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situation, KRS policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

KRS may change its policy at any time. When changes are made, a new Notice of Patient Information Privacy Practices will be posted in the waiting room and will be provided to you at your next visit. You may also request an updated copy at any time by calling our office, or by printing a copy from our website.

Patients Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, or when required by law or in emergency circumstances. KRS will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

Concerns and Complaints

For further information regarding our health information practices, or if you have a complaint or are concerned that KRS may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address on this Notice. You may also send a written complaint to the US Department of Health and Human Services.

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Patient Information Privacy Practices Acknowledgement Form

I have read and fully understand Kernersville Rehab Specialists LLC's **Notice of Patient Information Privacy Practices.** I understand that Kernersville Rehab Specialists may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of services provided. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Kernersville Rehab Specialists will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge and agree to the use and disclosure of my personal health information for purposes as noted in Kernersville Rehab Specialists LLC's **Notice of Patient Information Privacy Practices**. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____
Patient's Printed Name

_____
Patient's Signature

_____
Date

Kernersville Rehab Specialists, LLC
KRS
1031 E Mountain St
Bldg 318, Suite 101
Kernersville, NC 27284
336-996-4980
info@KRSTherapy.com
Aquatic & Land Based Physical/Occupational Therapy

PATIENT SURVEY

Name:

_____

Thank you for taking a moment to tell us how you chose Kernersville Rehab for your therapy services!

Please check all of the following sources in which you heard about our clinic:

- ☐ Telephone Book (Yellow Pages Listing)
- ☐ Internet Advertisement
- ☐ Our Webpage (www.krstherapy.com)
- ☐ Physician Referral
- ☐ Recommendation from family, friend, co-worker, etc.
- ☐ Workers' Compensation Insurance
- ☐ Previous Patient