

**THE HALE HAND CENTER PATIENT DATA SHEET**

**First:** \_\_\_\_\_ **MI:** \_\_\_\_\_ **Last:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** Male  Female

**Physical Address:** \_\_\_\_\_ **Mailing Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**May we send you text messages for your appointment reminders to the number(s) listed above?**  Yes  No

**May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above?**  Yes  No

**By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information**

**May we send you emails relating to your care with us?**  Yes  No  
**By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.**  
**Email:** \_\_\_\_\_

**Preferred language:** \_\_\_\_\_ **Interpreter required?**  Yes

**Date of Injury:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_  
**Injury Area:** \_\_\_\_\_ **Auto or Work Accident:**  Auto  Work  N/A

**State Where Accident Occured:** \_\_\_\_\_  
**Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days?**  Yes  No  
**Are you currently receiving or have you received other therapy services in the last 60 days?**  Yes  No

**Marital Status:**  
 Married  Single  Divorced  Widowed  Separated  Unknown

**Student Status:**  
 Full-Time  Part-Time  None

**EMPLOYMENT STATUS**

**Employment Status:**

Active Military    Full-Time    None    Part-Time    Retired    Self Employed

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Holder's Birth Date:** \_\_\_\_\_

**Policy or Certificate #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder's Employer:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Holder's Birth Date:** \_\_\_\_\_

**Policy or Certificate #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder's Employer:** \_\_\_\_\_

**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"/> Marketing Ad - Facebook            |
| <input type="checkbox"/> School         | <input type="checkbox"/> Screens - Open Houses  | <input type="checkbox"/> Marketing Ad - Other _____         |

Specify if other : \_\_\_\_\_

**Note: Please provide us with the most updated information below.**

**EMERGENCY AND OTHER CONTACTS**

Name	Phone	Work	Cell	Fax	Type

**DISCLOSURE OF MEDICAL RECORDS**

I authorize the following individuals to have access to my medical and billing records:

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

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

\_\_\_\_\_  
Date

**PATIENT INTAKE AND CONSENT FORM**

Internal Use Only:   A/C#                                  Name                                  A/C Type                                  Office #

**CONSENT TO TREATMENT**

I consent to rehabilitation and related services at: THE HALE HAND CENTER

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature.   **Initials:** \_\_\_\_\_

**TREATMENT OF MINORS**

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.                                  **Initials:** \_\_\_\_\_

**LIABILITY**

I know and agree that: THE HALE HAND CENTER is not responsible for loss or damage to personal valuables.                                  **Initials:** \_\_\_\_\_

**WAIVER AND RELEASE**

I hereby release, discharge and acquit: THE HALE HAND CENTER its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.                                  **Initials:** \_\_\_\_\_

**AUTHORIZATION OF PAYMENT**

I hereby assign all benefits directly to: THE HALE HAND CENTER  
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices.                                  **Initials:** \_\_\_\_\_

**FINANCIAL POLICY**

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.  
To assist in establishing your account, please:  
- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.  
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.  
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.                                  **Initials:** \_\_\_\_\_

**NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS**

I acknowledge receipt of Notice of Privacy Practices.                                  **Initials:** \_\_\_\_\_  
I acknowledge receipt of the Statement of Patient Rights.                                  **Initials:** \_\_\_\_\_

I certify that all of the information provided herein is true and correct.

**Patient/Guardian**                                  **Witness**  
**Signature** \_\_\_\_\_                                  **Signature** \_\_\_\_\_                                  **Date** \_\_\_\_\_

# Medical History Form

<b>Patient Name:</b>		<b>Today's Date:</b>	
<b>Referring Physician:</b>		<b>Date of Birth:</b>	<b>Age:</b>
<b>Primary Care Physician:</b>		<b>Date of Injury or Onset:</b>	
<b>Date of Next Physician Appointment:</b>			
<b>Reason for Therapy:</b>			
<b>Cause of Injury or Onset:</b> <input type="checkbox"/> Accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other: <b>If Other, please explain:</b>			
<b>Have you been hospitalized for the present condition?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, date:</b>			
<b>Did you have surgery for this condition?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, date:</b> If Yes, surgery type:			
<b>Are you currently receiving any other care for the condition mentioned above?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe:			
<b>Have you ever received therapy in the past for the condition mentioned above?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, date:</b> <b>Describe previous treatment:</b>			
<b>Previous Treatment:</b> <input type="checkbox"/> Successful <input type="checkbox"/> Unsuccessful			
<b>Have you fallen in the last year?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, how many times?</b> <b>If Yes, were you injured?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Do you feel unsteady when standing or walking?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Do you worry about falling?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>What are your personal goals/outcomes you hope to achieve from therapy?</b>			
<b>Describe your general health:</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<b>Do you smoke or use tobacco?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)</b>			
<input type="checkbox"/> Allergies <input type="checkbox"/> Latex <input type="checkbox"/> Other	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Kidney Problems	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy or Seizure Disorder	<input type="checkbox"/> Metal Implants	
<input type="checkbox"/> Anxiety or Panic Disorders	<input type="checkbox"/> Fainting	<input type="checkbox"/> MRSA	
<input type="checkbox"/> Arthritis <input type="checkbox"/> OA <input type="checkbox"/> RA	<input type="checkbox"/> Fatigue or Weakness	<input type="checkbox"/> Multiple Sclerosis	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fever or Chills	<input type="checkbox"/> Nausea / Vomiting	
<input type="checkbox"/> Use of Blood Thinners	<input type="checkbox"/> Fractures	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Bowel or Bladder Disorder	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Head Injury or Concussion	<input type="checkbox"/> Parkinson's Disease	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Peripheral Vascular Disease	
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Heart Disease or Heart Attack	<input type="checkbox"/> Respiratory or Breathing Problems	
<input type="checkbox"/> COPD	<input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Ringing in Ears	
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hernia	<input type="checkbox"/> Sexual Dysfunction	
<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/> Skin Abnormalities	
<input type="checkbox"/> Deep Vein Thrombosis (DVT)	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Stroke or TIA	
<input type="checkbox"/> Depression	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II	<input type="checkbox"/> Hypersensitivity to Hot or Cold	<input type="checkbox"/> Tuberculosis	
<b>List any other medical problems and explain:</b>			

# Medical History Form

## Medication List

Name of Medication	Dosage	Frequency	
<input type="checkbox"/> Check Box if Medication List provided separately.			
1.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
2.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
3.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
4.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
5.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
6.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
7.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
8.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
9.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
10.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
11.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
12.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
<b>Over the Counter Medications (check all that apply):</b> <input type="checkbox"/> Aspirin/Ibuprofen <input type="checkbox"/> Antacids <input type="checkbox"/> Sleeping Aids <input type="checkbox"/> Cold Medicine: <input type="checkbox"/> Cough Medicine <input type="checkbox"/> Allergy Relief <input type="checkbox"/> Laxative <input type="checkbox"/> Diet Pills <input type="checkbox"/> Vitamins/Herbal Supplements <input type="checkbox"/> Other:			

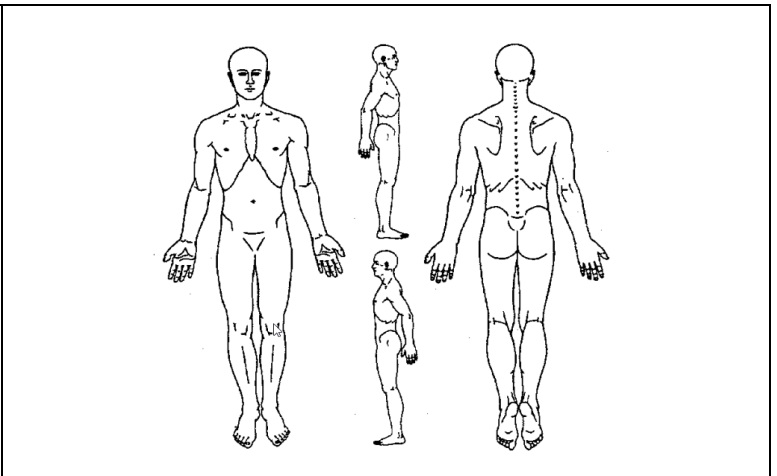
**Pain Scale**  
Rate the severity of your pain by circling a box on the following scale.

No Pain Worst Pain

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

**On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location.**

**KEY:**  
 A = Aching      B = Burning      N = Numbness  
 P = Tingling    S = Stabbing    O = Other



<b>Signature of Patient:</b>	<b>DOB:</b>
<b>Printed Name of Patient:</b>	<b>Date:</b>