Attachment B1.003A
Attachment M7.005C

PATIENT INTAKE AND CONSENT FORM

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

First Name ______ MI ______

Last Name ______

Address ______

______

City ______ State ______ Zip ______

Date of Injury/Onset ______ Today's Date ______

Date of Birth ______ Age ______

Sex ☐M ☐F Marital Status ☐S ☐M ☐D ☐W

Home Phone ______

Work Phone ______

Cell Phone ______

E-mail ______

Injury Area ______

Accident Related: ☐Yes ☐No

If Accident: ☐Auto ☐Work ☐Other

Nature of Accident ______

SS# ______

Responsible Party ______

Address ______

City ______

Phone Number ______

Relationship to Responsible Party ______

Employer ______

Address ______ Occupation ______

City ______ State ______ Zip ______ Contact at Employer ______

Referring Physician ______ Phone Number ______

Primary Insurance ______ Insured Name ______

Group # ______ ID # ______ Address ______ City ______

Insured Employer ______ State ______ Zip ______ Phone ______

Relationship to Insured ______ Insured Date of Birth ______ Insured Sex: ☐M ☐F

Second Insurance ______ Insured Name ______

Group # ______ ID # ______ Address ______ City ______

Insured Employer ______ State ______ Zip ______ Phone ______

Relationship to Insured ______ Insured Date of Birth ______ Insured Sex: ☐M ☐F

Emergency Contact ______ Daytime Phone Number ______

Are you receiving or have you received home health services? ☐Yes ☐No

Are you receiving or have you received other therapy services? ☐Yes ☐No

(Continued on next page)

Please Initial Each
as Applicable:

PATIENT INTAKE AND CONSENT FORM

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CONSENT TO TREATMENT: I consent to rehabilitation and related services at The Hale Hand Center. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of sensitive nature. ____________________

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. ____________________

LIABILITY: I know and agree that The Hale Hand Center is not responsible for loss or damage to personal valuables. ____________________

WAIVER AND RELEASE: I hereby release, discharge and acquit The Hale Hand Center, it's æ^}o•ÊÂ 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. ____________________

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment. ____________________

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. ____________________

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

Patient/Guardian Signature________________________ Witness Signature________________________

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M5.002A

THE HALE HAND CENTER
MEDICAL HISTORY FORM

PATIENT NAME: ____ TODAY'S DATE: ______________________
REFERRING PHYSICIAN'S NAME: ___________________________ DATE OF INJURY OR ONSET: ____________
PRIMARY CARE PHYSICIAN'S NAME: _________________________ ARE YOU PRESENTLY WORKING? Y ES NO
CAUSE OF INJURY OR ONSET: _____________________________ DATE OF NEXT MD APPT: _______________

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS: ____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: ___________________

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: __________

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO _________________

WHAT IS YOUR REASON FOR ATTENDING THERAPY: ____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?
1. ____
2. ____
3. ____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?
1. ____
2. ____
3. ____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? ______ WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN_______________
AND WHY____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?:
____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? ____

CURRENT MEDICATIONS: ____
____

ALLERGIES: Medication __________Reaction____________ Other _____________Reaction_____________________
ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction_________________________
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction__________________________________

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ CANCER
- ☐ CARDIOVASCULAR PROBLEMS
- ☐ HOLTER MONITOR - currently wearing?
  - ☐ PACEMAKER
  - ☐ HIGH BLOOD PRESSURE ☐ controlled ☐ uncontrolled
- ☐ LOW BLOOD PRESSURE
- ☐ CURRENTLY PREGNANT
- ☐ DIABETES ☐controlled ☐uncontrolled
- ☐ DEPRESSION
- ☐ DIZZINESS/FAINTING
- ☐ FRACTURES
- ☐ HEADACHES
- ☐ HEPATITIS/HIV
- ☐ KIDNEY PROBLEMS
- ☐ MRSA (Methicillin Resistant Staphylococcus Aureus)
- ☐ OSTEOPOROSIS
- ☐ RESPIRATORY PROBLEMS
  - ☐ ASTHMA ☐ controlled ☐ uncontrolled
  - ☐ COPD ☐ controlled ☐ uncontrolled
  - ☐ Other
- ☐ SEIZURES ☐ controlled ☐ uncontrolled
- ☐ THYROID PROBLEMS
- ☐ BLOOD THINNERS (Anticoagulants)

If checked any above, explain: ____

☐ **ANY OTHER MEDICAL PROBLEMS:** ____

SIGNATURE OF PATIENT: ________________________ REVIEWED BY Therapist: _________________Date____________

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