PATIENT (LEGAL) NAME:_____ SEX:_____ BIRTHDATE:_____

PREVIOUS/MAIDEN NAME(s): _____ SSN:_____

PHYSICAL ADDRESS:_____
City State Zip

MAILING ADDRESS:_____
City State Zip

PHONE: HOME/CELL:_____ EMAIL: _____

EMPLOYER:_____ PHONE:_____

SPOUSE NAME:_____ SPOUSE DOB:_____ PHONE:_____

EMERGENCY CONTACT (OUTSIDE OF HOME):_____ PHONE:_____

HOW DID YOU HEAR ABOUT US? _____

WORK COMP BILLING INFORMATION

WORK COMP CARRIER:_____ CLAIM NUMBER:_____

ADDRESS:_____ PHONE:_____

CLAIMS ADJUSTER:_____ PHONE:_____

DATE OF INJURY:_____ EMPLOYER NAME AT TIME OF INJURY:_____

ATTORNEY:_____ PHONE:_____

SHOULD THE WORK COMP INSURANCE DENY LIABILITY FOR THE CHARGES, YOU ARE FINANCIALLLY RESPONSIBLE.

WE CAN BILL YOUR PRIVATE INSURANCE

(**Please note**: *Please provide your private insurance information and/or a copy of your Insurance Card.)*

POLICYHOLDER NAME:_____ DOB:_____ RELATION:_____

NSURANCE COMPANY:_____ ID/CLAIM #:_____GROUP #:_____

_____ _____

SIGNATURE OF RESPONSIBLE PARTY (PATIENT OR PARENT/GUARANTOR IF PATIENT IS A MINOR) DATE

NAME: _____ DATE: _____

A. PLEASE READ AND ANSWER THE FOLLOWING QUESTIONS:

1. ARE YOU CURRENTLY ENGAGING IN ANY FORM OF EXERCISE? _____

IF YES, LIST ACTIVITY, FREQUENCY AND INTENSITY: _____

2. HOW ACTIVE IS YOUR LIFESTYLE? _____ SEDENTARY ____ MODERATE PHYSICAL ACTIVITY _____ HEAVY PHYSICAL ACTIVITY

3. WHAT IS YOUR JOB TITLE IF CURRENTLY WORKING?_____
DESCRIBE THE TYPES OF ACTIVITIES INVOLVED IN YOUR JOB (HEAVY LIFTING, STAIR CLIMBING, WALKING, SITTING AT DESK, ETC):

_____

_____

4. PLEASE INDICATE YOUR EXPECTATIONS AND GOALS FOR YOUR TREATMENT:_____

_____

B. **PLEASE FILL OUT YOUR PAIN LEVELS AND MARK WHERE YOU ARE FEELING THE PAIN ON THE DIAGRAM BELOW.**

PAIN / DISCOMFORT/DIZZINESS DESCRIPTION

SYMPTON FREQUENCY:

_____ CONSTANT
_____ COMES AND GOES AT REGULAR TIMES
_____ HAPPENS ONCE IN A WHILE

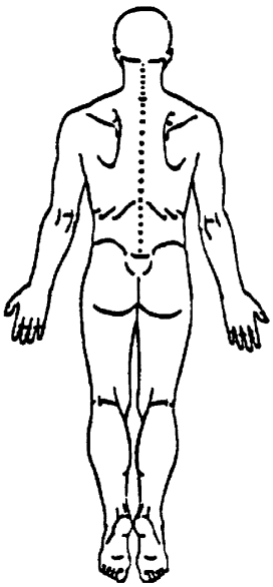
RELATIONSHIP OF SYMPTOMS TO SLEEP:

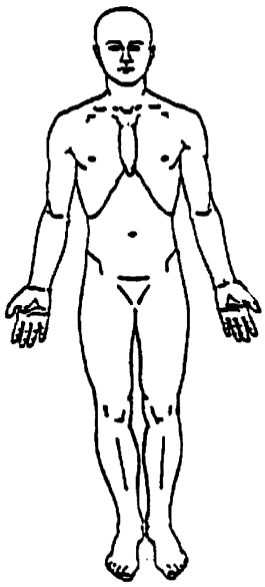
_____ WAKES FROM SLEEP
_____ PREVENTS SLEEP
_____ BETTER AFTER SLEEP

SYMPTOM SCALE- 0 BEING NONE AT ALL 10 BEING AS BAD AS IT CAN BE

AT WORST	0	1	2	3	4	5	6	7	8	9	10
CURRENT	0	1	2	3	4	5	6	7	8	9	10
AT BEST	0	1	2	3	4	5	6	7	8	9	10

Key: /// Stabbing XXX Burning 000 Pins & Needles === Numbness





PATIENT SIGNATURE:
_____ DATE:_____

NAME:_____ DATE:_____

MEDICAL HISTORY:

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

_____ ALZHEIMER'S	_____ HIGH BLOOD PRESSURE	_____ OSTEOARTHRITIS
_____ CARDIOVASCULAR DISEASE	_____ HISTORY OF CANCER	_____ PARKINSON'S
_____ CURRENT INFECTION	_____ HUNTINGTON'S	_____ PREGNANT/POSSIBLY PREGNANT
_____ CVA/STROKE	_____ LUPUS	_____ RHEUMATOID ARTHRITIS
_____ DIABETES TYPE 1/TYPE 2 (CIRCLE)	_____ MUSCULAR DYSTROPHY	_____ TRAUMATIC BRAIN INJURY
_____ FIBROMYALGIA	_____ HIV, HEPATITIS B, HEPATITIS C	

_____ PREVIOUS FRACTURED BONES (IF SO WHICH ONES):_____

SURGICAL HISTORY:_____

OTHER: _____

PLEASE LIST BELOW YOUR CURRENT PRESCRIPTION(S), OVER-THE-COUNTER, HERBAL, VITAMIN/ MINERALS / DIETARY (NUTRITIONAL SUPPLEMENTS) MEDICATIONS. IF YOU HAVE A CURRENT LIST OF YOUR MEDICATIONS WITH ALL OF THE BELOW INFORMATION, PLEASE PROVIDE IT TO THE FRONT OFFICE AND THEY CAN MAKE A COPY.

PRESCRIPTION MEDICATIONS:

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

OVER-THE-COUNTER / HERBAL/ VITAMIN /MINERAL / DIETARY (NUTRITIONAL SUPPLEMENT):

MEDICATIONS	DOSAGE	FREQUENCY	ROUTE (EX:ORALLY)	REASON FOR TAKING

For Future Appointments Only

I _____, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:_____ DATE:_____

I _____, AFFIRM THAT THE ABOVE MEDICATION LIST AND MEDICAL HISTORY IS ACCURATE AND ANY NECESSARY CHANGES HAVE BEEN MADE.

SIGNATURE:_____ DATE:_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

I, _____, acknowledge that Advanced Performance and Rehabilitation Services office has a posted Notice of Privacy Practice available in the patient reception area. A copy is available by request.

_____ _____
Signature Date

AUTHORIZED RELEASE OF INFORMATION

Patient Name: _____

I have been referred to Advanced Performance and Rehabilitation Services, Inc. for evaluation and treatment for my on-the-job injury. I understand that signing this form authorizes the release to the workers' compensation insurer or its agent, rehabilitation records, Social Security records, and health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA) that are directly relevant to the claimed injury, disease or death.

_____ _____
Signature Date

UPDATED 03/2016