SpinelineRehab New Patient Information

Patient Information

First Name:	Middle Name:	Last Name:	
Address:	City:	State:	Zip:

DOB: (mm/dd/yyyy)	Age:	Sex: ☐ M ☐ F	Marital Status: ☐ S ☐ M ☐ W ☐ D

Cell Phone:	Home phone:	Work phone:

Email:	

Employer:	Occupation:

Parent/Guardian/information (only for patient under 18)

Name:	Cell phone:		
Address:	City:	State:	Zip:

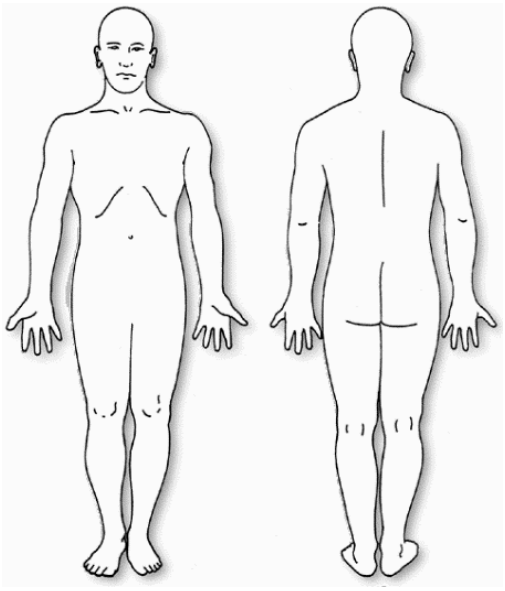
Emergency Contact

Name:	Cell phone:

Physician Information

Primary Physician's name:	Phone number		
Address:	City:	State:	Zip
Specialist Physician's name:	Phone number		

How did you hear about our practice?

What is the primary problem/issue that brings you in today?	
The history of your current condition	
How is this condition limiting your daily life?	
Is there any test being done? (X-ray, MRI. CT scan, ultrasound)	
Please rate your pain in the past week. Using the "0-10" scale where 0 is no pain and 10 is the worst possible pain.	**Please mark/shade your painful area**
At its worst:	
At its best:	
At present:	
During sleep:	
At what time of day is your symptoms the worst?	
At what time of day is your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	
Any previous treatment before? If yes, what kind?	

Check the box if you have the following medical condition/s							
	Diabetes		Cancer		Pace maker		pregnancy
	Rheumatic fever		Liver disease		Varicose vein		Blackouts
	Heart murmur		Sudden weight loss		Epilepsy/seizures		High blood pressure
	Circulatory problems		Migraine headaches		Fracture		
	Lung disease		Arthritis		Kidney disease		
	osteoporosis		Heart disease		Neurological issues		Others (explain below)

Please list past medical history with dates of occurrence, including surgery and traumas

Please list all medications that you are currently taking

medication	For treatment of	Dose/day	Effectiveness

Please list all your allergies

What is your goals for therapy?

Do you exercise regularly?
What kind and how often?

In general, your lifestyle is:	1	2			
	Active		Average		Inactive

Patient signature:_____ **Date:**_____

Informed Consent

I understand that SpinelineRehab will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Photographs taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below I consent to the use of these photographs in a professional manner.

I do hereby agree and give my consent for SpinelineRehab to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
I hereby certify that all the above information is true to the best of my knowledge.

Payment Policy

Payment, in the form of cash, check or credit card, is due at the time of each visit. We are not contracted with any insurance companies. However, the payments you make may be reimbursable by your insurance company under your out of network physical therapy benefits; the exact percentage depends upon your plan.

I have read, understand and agree to the above written statements and payment terms.

***Patient/Parent/Guardian* signature: _____Date: _____**