Atlantic Rehabilitation: Patient Information

General Information

First Name: _____ MI:_____ Last Name:_____

DOB:_____ Age:_____ Gender: Male:_____ Female:_____

Address:_____ Apt#:_____

City:_____ State:_____ Zip:_____

Home #: _____ Work #:_____

Cell#: _____

Appt Reminder Option: Text:_____ Email:_____ Check One: ○ Non-Smartphone

Email Address:_____

Marital Status: Married:_____ Single:_____ Divorced:_____ Widowed:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Phone#:_____

Date of Injury/Onset:_____(MM/DD/YYYY)

Was this work related or due to an injury: Work:_____ Auto:_____ Other:_____

How did this injury occur?_____

How were you referred to us? Physician:_____ Case Manager:_____ Insurance Co:_____ Friend:_____ Other:_____

Employer Information:

Employer Name:_____ Occupation/Job Title:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

Does your work expose you to:

- ○ Stress
- ○ Prolonged Sitting
- ○ Computer work
- ○ Heavy Lifting
- ○ Prolonged Standing

Circle One: Insured Guarantor Worker's Compensation Auto Accident Self-Pay

Relationship to Insured: Self Spouse Child Other:_____

First Name:_____ MI:_____ Last Name:_____

Address:_____ Apt#:_____

City:_____ State:_____ Zip:_____

Gender: Male:_____ Female:_____ Date of Birth:_____ Age:_____

Cell#:_____ Home#:_____

Signature:_____ **Date:**_____

Height: _____ ft. _____ in. **Weight**: _____ lbs.

Health History

List any

- Arthritis (rheumatoid/osteoarthritis)
- Osteoporosis
- Asthma
- Chronic Obstructive Pulmonary Disease(COPD), Acquired respiratory disease (ARDS), or emphysema
- Angina
- Congestive Heart Failure (or heart disease)
- Heart attack (Myocardial Infarction)
- High blood pressure
- Neurological Disease (such as Multiple Sclerosis or Parkinson's)
- Stroke or TIA
- Peripheral Vascular Disease
- Headaches
- Visual impairment (such as cataracts, glaucoma, macular degeneration)
- Hearing impairment (very hard of hearing, even with hearing aids)
- Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- Kidney, bladder, prostate, or urination problems
- Previous accidents
- Allergies
- Incontinence
- Anxiety or panic Disorders
- Depression
- Other Disorders
- Hepatitis, Tuberculosis, HIV, AIDS, or other blood-borne condition

hobbies or interests:_____

On a scale from 0 to 10 (0 being no pain and 10 being worst pain), how would you rate your pain:_____

Are you currently taking any pain medication: Yes No

Are you receiving home health services? Yes No **Have you had physical therapy services this year?** Yes No

List any allergies to medication or substances:_____

Please list any medications, vitamins, or herbal supplements that you take		
Medication/Vitamins/Herbal Supplements	**Dosage and frequency taken**	**Reason for taking**