College Station Medical Center Therapy Services

PLEASE PRINT ALL INFORMATION

Referring Physician: ________________________Physician's Phone Number: ______________________

Today's Date:________________ Time: ________ Patient Social Security Number: __________________

Patient Name: ________________ Phone: _______ Date of Birth: ________________________________

Sex: ________ Race: __________ Marital Status: ___________ County: ___________________________

Current Street Address: ____________________ City: ______________ State: _____ Zip: _____________

Mailing Address: _________________________ City: ______________ State: _____ Zip: _____________

Employment Status: (please circle) Full time Part time Self Employed Retired

Unemployed Disabled Full Time Student

Position: ________________________________ Employer Phone: ____________________________

Name of Employer: _______________________ Employer Address: ___________________________

Person to Contact in Case of Emergency

<u>Please use spouse if married or parent if a minor.</u>

Name: ______________________________________ **DOB:** ________________ **Sex:** ____________

Address: ____________________________________ **City:** ____________**State:** ______ **Zip:** _____

Home Phone: ________________________________ **Work Phone:** ___________ **Relationship:** ___

Soc. Sec. #: _____________________________________ **Occupation:** ___________________________

Name of Employer: ____

Employer's Address: ____ **City:** ________ **State:** _________

Employment Status: (please circle) Full time Part time Self Employed Retired

Position: ________________ **Unemployed Disabled Full Time Student**

INSURANCE INFORMATION

(*We must have a copy of your insurance card or w/c or Auto Billing information*)

Insured person's name: ___________________________________ Social Security Number: ___________

Date of Birth: ____________ Employer's Phone Number: __________________________________

Insured Person's Employer: ____

Employer's Address: ____

Medical History

Name: ______________________________________Age: ________________ Date of Birth: __________

Please list any known food or drug allergies:

Food: _______________________________________ Drug: _____________________________________

Previous Medical or Surgical History: ____
____
____

Are you receiving any home health care at this time? Yes No (circle one)

If yes, please inform the receptionist at this time. Medicare recipients may be excluded from receiving outpatient therapy at the same time they are receiving home health care without proper coordination of benefits.

Please circle the correct answer:
Do you have a history of:

Active or persistent coughing	Y/N	Diabetes	Y/N
Dizziness	Y/N	Fever or Night Sweats	Y/N
Frequent Falls	Y/N	High Blood Pressure	Y/N
Limited Hearing	Y/N	Seizures	Y/N
Loss of Appetite	Y/N	Shortness of breath	Y/N
Unexplained Weight Loss	Y/N	Glasses	Y/N
Low Blood Pressure	Y/N	Severe Night Pain	Y/N
Inability to Exercise	Y/N	Reduced Vision	Y/N

Do you have a history of heart attack, chest pain, or pacemaker? ___________________________
Do you give blood or blood products on a regular basis? **Yes No** Last given on ______________

Highest education attained: HS diploma Some college College Degree Post-graduate

Primary Language Spoken: _________________________________

Do you have religious or cultural preferences that we might accommodate during the course of your therapy? If so, please list:____

Please list all of your current medications and associated information:

Medication	Dosage	Frequency	Last Taken
Example: Aspirin	81 mg	1 time per day	Today

What is your current complain or condition?____

Date of onset: ___________________Surgery Date (if applicable): ________________________________

Are you aware of your diagnosis? **Yes** **No** Are you aware of your prognosis? **Yes** **No**

Has the Physician given you any precautions the therapist needs to be aware of? **Yes** **No**

If so, what are they?

____

What is your vocation? ____________________________________currently employed? **Yes** **No**

Currently working? **Yes** **No** Last day worked: ____________________________________

Please list your goals or family goals for this therapy:

____ ____

Only answer the question below if there was an accident (i.e. car or third party)

Is this related to an accident? Yes No

If yes, explain: ____

Date of accident: _________________________________ County/State Accident Occurred in: ______

Is there a letter of subrogation on file? Yes No

Only answer the question below if your condition is job related:

Is your condition job related: Yes/No If yes, has a claim been filed? Yes/No

Who is your employer? ______________________________ Contact: _____________________________

Phone Number of contact: ____________________________ How long have you worked there? ________

Date of current injury: ______________________________ Do you have other work injuried? Yes/ No

Have you had other treatment for your current injury for your current injury since onset? Yes/ No

When? ____

Choose a number from 0 to 10 that best describes your pain: _________
(0 = no pain, 5 = distressing pain, 10 = unbearable pain)