



**WELCOME TO TRI-REHAB, INC.
WE LOOK FORWARD TO WORKING WITH YOU!**

DATE: _____ **REFERRING DOCTOR:** _____

PATIENT'S NAME (LAST) (FIRST) (M.I.) (MAIDEN)

ADDRESS CITY STATE ZIP

HOME PHONE WORK PHONE CELL PHONE E-MAIL

SEX BIRTHDATE MARITAL STATUS SOCIAL SECURITY #

OCCUPATION PATIENT'S EMPLOYER EMPLOYER'S ADDRESS

SPOUSE'S NAME (LAST) (FIRST) (M.I.)

SPOUSE'S ADDRESS CITY STATE ZIP

EMERGENCY CONTACT PHONE #

HOW DID YOU HEAR ABOUT TRI-REHAB, INC.?



MEDICAL HISTORY

_____ **High Blood Pressure**

_____ **Tuberculosis**

_____ **Heart Murmur**

_____ **Jaundice**

_____ **Other Heart Problems**

_____ **Rheumatic Fever**

_____ **Asthma**

_____ **Venereal Disease**

_____ **Epilepsy/Seizures**

_____ **AIDS/HIV (+)**

_____ **Fainting**

_____ **Nervous Disorders**

_____ **Allergies**

_____ **Implants**

_____ **Chronic Headaches**

_____ **Previous Back Pain**

_____ **Pacemaker**

_____ **Hepatitis**

_____ **Diabetes**

_____ **Cancer**

Are you pregnant? _____

Have you ever had physical therapy before? _____ **If so, when and for what?** _____

_____ **Did the physical therapy help?** _____

History of Present Illness/Injury: _____

Past Surgeries/Dates? _____

Medications: _____



ATTENDANCE POLICY

You have been referred to Tri-Rehab, Inc. due to a physical problem or disability. The maximal benefits of rehabilitation can only be achieved if you are very serious about *your* program and follow the instructions you are given.

Attendance at rehabilitation is mandatory unless severe circumstances (illness, etc.) prevent you from making your appointment.

In the event that you must miss an appointment, it is your responsibility to call our office in advance to avoid no show status. Our office will kindly reschedule your appointment within your current prescription.

If you do not show for a scheduled appointment, it is your responsibility to reschedule the appointment at your next visit or by telephone. In the unlikely event that three appointments are missed within the current doctor's prescription, your physician and insurance representative/employer will be notified. Excessive cancellations and no shows will result in discharge from services at Tri-Rehab, Inc.

While attending your rehabilitation sessions, only patients are permitted in the treatment area or on the equipment.

*** PATIENT RESPONSIBILITY ***

You will be held responsible for your insurance coverage, co-pays and deductibles. Tri-Rehab encourages all patients to call their insurance carrier and request a quote of their physical rehabilitation benefits.

I have read and understand the attendance and patient responsibility information above.

Patient signature _____ Date _____

Guardian signature _____ Date _____



Notice and Acknowledgement

Acknowledgement:

I acknowledge that I have received the attached Notice of Privacy Practices.

Patient or Personal Representative Signature

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:
