Advanced Rehab and Health Specialists - Health History Form

**Please Complete Form in its Entirety

Date __________________________ Name ____

Date of Birth _____/_____/_____ Sex: M F Social Security Number ______-______-__________

Home Address ____
(Street) (City) (State) (Zip)

Phone Number ____________________ Home or Cell Email Address:_______________________________

Emergency Contact _____________________________ Emergency Contact Number _____________________

Referring/Primary Care Physician ______________________________ PCP Number _____________________

Tell Us Aabout Yourself

How Would You Say Your Overall Health is at This Time, Taking in Account the Reason You are Here Today?

Circle Just One Answer: Excellent Very Good Good Fair Poor

Please Check any of the following Whose Care you are currently under:

_____ Medical Doctor _____ Psychiatrist/Psychologist _____ Physical Therapist

_____ Dentist _____ Chiropractor _____ Massage Therapist _____Personal Trainer

If you have seen any of the above in the last 3 months, what was the reason? _______________

____

Medications Name and Dosage Amount

*Please list which **prescription or over the counter medication** you have taken in the last week: (Exclude Vitamins)

1. ______________________________________ 4. ______________________________________
2. ______________________________________ 5. ______________________________________
3. ______________________________________ 6. ______________________________________

Medical History

*Have you had or Do You Presently Have ANY of the Following? (Check if "YES")

__ Allergies
__ Anemia
__ Anxiety
__ Arthritis
__ Asthma
__ Autoimmune Disorder
__ Cancer
__ Cardiac Conditions
__ Cardiac Pacemaker
__ Chemical Dependency
__ Circulation Problems
__ Covid -19
__ Currently Pregnant
__ Depression

__ Diabetes
__ Dizzy Spells
__ Emphysema/Bronchitis
__ Fibromyalgia
__ Fractures
__ Gallbladder Problems
__ Headaches
__ Hearing Impairment
__ Hepatitis
__ High Cholesterol
__ High/Low Blood Pressure
__ HIV/AIDS
__ Incontinence
__ Kidney Disease

__ Metal Implants
__ MRSA
__ Multiple Sclerosis
__ Muscular Disease
__ Osteoporosis
__ Parkinsons
__ Rheumatoid Arthritis
__ Seizures
__ Smoking
__ Speech Problems
__ Stroke
__ Thyroid Disease
__ Tuberculosis
__ Vision Problems

Life Style and Exercise Habits

Do You Feel You Are?

__ Sedentary

__ Moderate Physical Activity: Walk >30min 5 days/Wk

__ Vigorous Physical Activity: Run >20min 3 days/Wk

What is Yout Job Description?

__ Sedentary (Desk/Office Work)

__ Moderate (Student/Factory)

__ Active (Heavy Laborer)

Yes No During the Past Month Have You Been Feeling Down, Depressed, Having Little Interest or Pleasure in Doing Things?

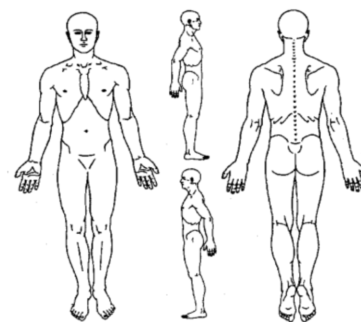
Yes No During the Past 12 Months Have You Fallen Down? If so, How Many Times? ____

Surgeries and/or Hospitalizations

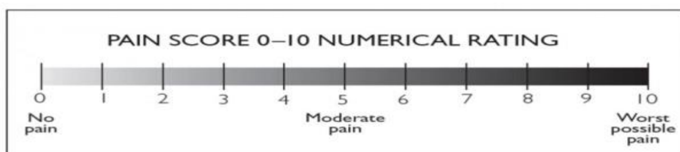
*Please Include Dates and Reason

1. ______________________________________ ____
2. ______________________________________ ____
3. ______________________________________ ____

Use the Diagram to Indicate Where Your Having Pain or Other Symptoms.



Use Pain Scale to Indicate Level of Pain.



CONSENT TO TREATMENT: I have read, understood, and verified that the above information is true and correct. I realize I am a partner in my treatment and will be informed of my plan of care, goals and expected outcomes. I realize that I can openly discuss questions or concerns with ARHS staff in a confidential manner.

***CANCELLATION POLICY.** Should you need to cancel/reschedule an appointment please do so 24-Hours before your appointment time. Failure to do so will result in a $25 charge to your account. We realize emergencies arise and are sometimes unavoidable; however, advanced notification allows us to keep the office operating efficiently.

***YOUR CO-PAY IS DUE AT EACH VISIT**. Should your insurance deny payment, you will be responsible for outstanding charges. If your Insurance pays you, you will remit payments to ARHS.

***PATIENT ACCOUNT POLICY**. A patient's account is not allowed to exceed more than $250 and/or 30 days past due. If this should occur the patient WILL BE REQUIRED to make payment in full before care will be continued.

*****I acknowledge** Advanced Rehabilitation and Health Specialists are in compliance with all HIPAA and Privacy Policies.

*****I Authorize** Advanced Rehabilitation and Health Specialists to discuss my health information with:

1. ___________________________________ 2. ___________________________________

PRINT PATIENT NAME:____

PATIENT SIGNATURE: ____ DATE: _______________

PARENT'S SIGNATURE IF MINOR: ___________________________________ DATE: _______________