LAFAYETTE Rehabilitation Services

A UNITY HEALTHCARE PARTNER

Name: _____ **I prefer to be called:** _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: Home: _____ **Work:** _____ **Cell:** _____

Email address: _____ **Gender:** ☐M ☐F **Hand Dominance:** ☐R ☐L

Emergency Contact: _____ **Relationship:** _____ **Phone Number:** _____

Have you been a patient here before? ☐Y ☐N **If yes, for** ☐ the same or ☐ a different problem?

How did you hear about us? ☐ Physician ☐ Friend/Family Member ☐ Other: _____

Primary Care Physician: _____ Therapy evaluations will be copied to your PCP (☐Do not send)

Have you had any other therapy this calendar year? ☐Y ☐N **If yes, for:** ☐Physical ☐Occupational ☐Speech

For what body region(s) are you seeking treatment? (please circle) Neck Mid-Back Lower Back
Shoulder Elbow Hand Wrist Hip Knee Ankle Foot Other: _____

When did your symptoms start? _____ **Can you identify a cause for your symptoms:** ☐Y ☐N

If related to an injury, what kind? (please circle) Auto Work Athletic Liability Other: _____

Have you retained an attorney as a result of this injury? ☐Y ☐N **If yes, name:** _____

If this is a work injury, employer name: _____

Have you had surgery related to this diagnosis? ☐Y ☐N **If yes, when?** _____

Circle your *AVERAGE* level of pain: 0 (No pain) 1 2 3 4 5 6 7 8 9 10 (Emergency Room)

Does your pain move/radiate anywhere? ☐Y ☐N **If yes, where?** _____

Have you had any changes in your bowel/bladder/sexual function due to these symptoms? ☐Y ☐N

Have you ever had an allergic reaction to: Latex Band-Aids Cortisone Gel Lotion Beeswax

Have you fallen in the last year? ☐Y ☐N **How many times?** _____ **Did you get hurt?** ☐Y ☐N

Do you live alone? ☐Y ☐N **Do you have a friend/family member to help you if needed?** ☐Y ☐N

Do you smoke/use tobacco products? ☐Y ☐N **Is there a chance you could be pregnant?** ☐Y ☐N

1411 S. Creasy Lane, Suite 100 | Lafayette, IN 47905 | Phone: 765.447.5552 | Fax: 765.449.1054
3451 Wyndham Way, Suite D | West Lafayette, IN 47906 | Phone: 765.446.5250 | Fax: 765.446.5208
www.lafayetterehabilitation.com

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Please list all medications you are currently taking, including prescription, over-the-counter, & supplements:

Use back of this page if necessary. If you have a written list with you, our receptionist can make a copy for you.

Medication Name	Dosage/Frequency	Reason for Taking

Please list any relevant surgeries, including when they were performed (month and/or year):

_____

_____

_____

Is your general health (please circle one): Excellent Good Fair Poor Very Poor

What other medical problems do you or have you had?

☐ High Blood Pressure	☐ Diabetes	☐ Osteoarthritis	☐ Stroke	☐ Heart Disease
☐ Depression/Anxiety	☐ Cancer	☐ Rheumatoid Arthritis	☐ Heart Attack	☐ Lung Problems
☐ Parkinson's Disease	☐ Asthma	☐ Kidney Failure	☐ Gout	☐ Blood Clots
☐ Osteopenia/Osteoporosis	☐ Seizures	☐ Hard of Hearing	☐ HIV/AIDS	☐ Hard of Hearing
☐ Alzheimer's/Dementia	☐ Pacemaker	☐ Other:		

AUTHORIZATION STATEMENT

I authorize and consent to treatment at Lafayette Rehabilitation Services (LRS).

I authorize release of my medical records to my physician, insurance company, employer, rehab nurse, and any other party that may have an interest in payment of my rehabilitation.

I acknowledge that I have access to a copy of LRS's notice of privacy practices that describes my rights and LRS's duties with respect to my protected health information.

Patient Signature: _____ Date: _____

Guarantor's Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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