NORTH OKALOOSA MEDICAL CENTER
in association with
ANDREWS INSTITUTE REHABILITATION

550 W Redstone Avenue, Ste. 100
Crestview, Florida 32536

PATIENT DEMOGRAPHICS

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers (please check preferred number):

☐ Home _____ ☐ Work _____ ☐ Cell _____

Social Security Number: _____ DOB: _____ Age: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Insured Name: _____ DOB: _____

SSN: _____ Relationship: _____

Are you retired? ☐ Yes ☐ No If yes, when? _____

Is spouse retired? ☐ Yes ☐ No If yes, when? _____

Insured Employee: _____ Phone Number: _____

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Patient Employer: _____ Occupation: _____

Employer Address: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Are there religious or cultural practices that should be part of your care? ☐ Yes ☐ No Please list _____

This Section To Be Filled Out By Clinical Staff.

Abuse Concerns:
☐ None
☐ Unexplained fractures/spiral fractures
☐ Unexplained bruises/various stages of healing
☐ Suspicious burns
☐ Injury patterned after objects (rope/teeth/hand/utensils…)
☐ Withdraws/depressed/afraid of others

Neglect Concerns:
☐ None
☐ Malnutrition/dehydration
☐ Not taking medications at home (low drug levels)

Concerned: ☐ Yes ☐ No

NORTH OKALOOSA MEDICAL CENTER
in association with
ANDREWS INSTITUTE REHABILITATION

550 W Redstone Avenue, Ste. 100
Crestview, Florida 32536

PAST MEDICAL HISTORY

NAME: _____ **DOB**: _____ **DATE:** _____

ARE YOU PREGNANT? YES ☐ NO ☐

HOW DO YOU PREFER TO LEARN NEW INFORMATION? Pictures ☐ Demonstration ☐ Verbally ☐

MY MAIN GOAL(S) FOR THERAPY IS: _____

_____

_____

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST: (list specifics where applicable)

Arthritis	Yes	No	_____
Asthma/emphysema/COPD	Yes	No	_____
Blood Clot	Yes	No	_____
Bowel/Bladder	Yes	No	_____
Bronchitis	Yes	No	_____
Cancer	Yes	No	_____
Chest Pain	Yes	No	_____
Diabetes	Yes	No	_____
Dizziness	Yes	No	_____
Frequent Headaches	Yes	No	_____
Frequent Nausea	Yes	No	_____
Gout	Yes	No	_____
Hearing Loss	Yes	No	_____
Heart Condition	Yes	No	_____
Hernia	Yes	No	_____
High Blood Pressure	Yes	No	_____
Numbness/Tingling	Yes	No	_____
Osteoporosis (bone thinning)	Yes	No	_____
Pacemaker	Yes	No	_____
Seizures	Yes	No	_____
Sprains/Strains/Fractures	Yes	No	_____
Vision Disorders	Yes	No	_____
Other	Yes	No	_____

NORTH OKALOOSA MEDICAL CENTER
in association with
ANDREWS INSTITUTE REHABILITATION

550 W Redstone Avenue, Ste. 100
Crestview, Florida 32536

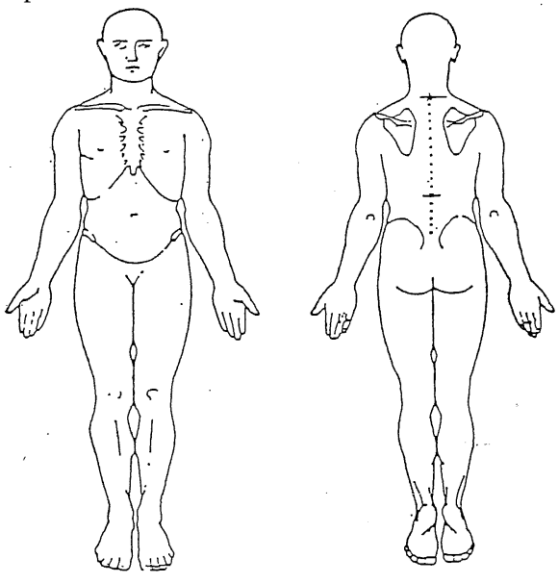
Patient Name: _____ DOB: _____

Onset of injury/pain: _____

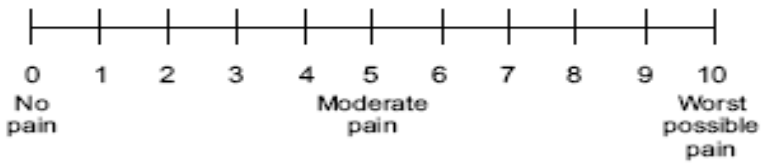
Please indicate your functional abilities in the following areas:

Limitations are:	None	Slight	Minimal	Moderate	Severe	N/A
Sitting longer than 15 minutes	☐	☐	☐	☐	☐	☐
Standing longer than 15 minutes	☐	☐	☐	☐	☐	☐
Walking longer than 15 minutes	☐	☐	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐	☐
Recreational Activities	☐	☐	☐	☐	☐	☐
Work Activities	☐	☐	☐	☐	☐	☐

Please indicate below where your pain is located:



CHOOSE A NUMBER 0 TO 10 THAT BEST DESCRIBES YOUR PAIN



CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL

SIGNATURE: _____ DATE: _____