1CNT

Patient Name _____ Date of Birth _____

Physician Name _____ Date _____

We appreciate you choosing our facility for your therapy services. Your therapist has recommended your initial treatment to be _____ times per week for _____ weeks. Based on your progress, the frequency or duration of your treatment may be adjusted in the future.

We want to ensure you are aware of the importance of consistency in your attendance of these appointments. First and foremost, we are committed to assisting you to the highest level of functional independence as possible. This requires consistent delivery of the therapy service specific for your plan of care. Second, we will reserve a therapy staff member to work specifically with you during your appointment times.

We realize that scheduling conflicts do occur and ask that you contact us as soon as you realize you have a conflict. Our goal will be to reschedule that appointment within the same week. Regulations that govern our therapy service require that your physician reviews your plan of care.

Our policy includes:

- Forwarding a copy of the initial evaluation/plan of care to your physician.
- Forwarding pertinent revisions to your plan of care to your physician.
- Notifying your physician when missed visits potentially affect your plan of care.
- If applicable, notifying your insurance representative of missed visits.

My signature below reflects that I have been informed and understand the above and states my commitment to attending my appointments.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Patient Label

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

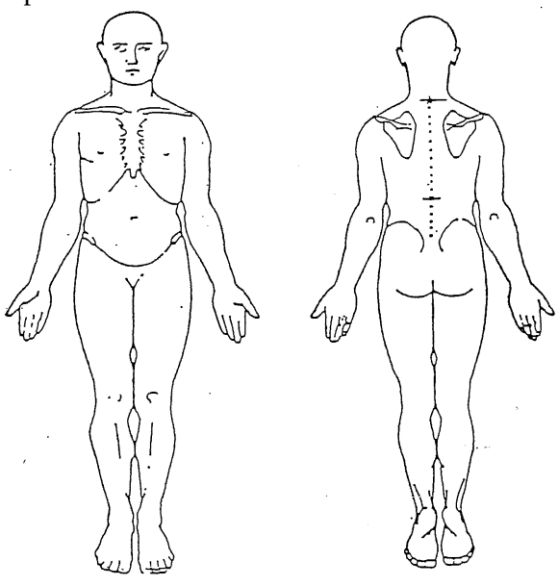
Patient Name: _____ DOB: _____

Onset of injury/pain: _____

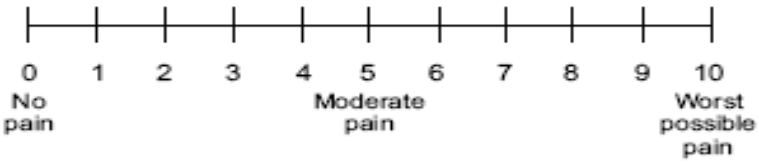
Please indicate your functional abilities in the following areas:

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: _____

2REHAB

Please complete the following to the best of your ability. This needs to be completed by the 3rd Visit. Your therapist will review this with you on your initial evaluation. After you have completed this form, please sign and date it on the bottom of page two (2).

Known Adverse and Allergic Reaction/Known Allergies

☐ None on Initial Review

Date	Allergy/Reaction	Date	Allergy/Reaction

Known Significant Medical Conditions Not Noted on Background Information Form

☐ None on Initial Review

Known Surgical and Invasive Procedures

☐ None on Initial Review

Date	Procedure

Known Current Medications: Prescription/Over the Counter/Herbals/Vitamins/Supplements

List routine medications, nutritionals, herbal supplements, patches, inhalers, ointments used.
If you have a list of medications on another document that we can attach, please **CHECK HERE** ☐
(see attached document with complete list of meds)

☐ None on Initial Review

MEDICATION (Include strength if known)	DIRECTIONS (if known) DOSE	ROUTE	FREQUENCY	Discontinued/Added (date and initial)
Example: Aspirin 81 mg	*1 tab*	*by mouth*	*daily*	
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added

Patient Label

Known Current Medications: Prescription/Over the Counter/Herbals/Vitamins/Supplements

List routine medications, nutritionals, herbal supplements, patches, inhalers, ointments used.
If you have a list of medications on another document that we can attach, please **CHECK HERE** ☐
(see attached document with complete list of meds)

☐ **None on Initial Review**

MEDICATION (Include strength if known)	DIRECTIONS (if known)			Discontinued/Added (date and initial)
	DOSE	ROUTE	FREQUENCY	
Example: Aspirin 81 mg	*1 tab*	*by mouth*	*daily*	
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added

Patient Signature	Date	Time
Intake Therapist Signature	Date	Time
FOR CHANGES		
Therapist Signature	Date	Time
Therapist Signature	Date	Time
Therapist Signature	Date	Time
Therapist Signature	Date	Time

Patient Label