CrossRoads - *Medical History Form*

Patient Name: _____ **Nickname:** _____
Last First MI

Chief Complaint: _____

Current Symptoms: □ Pain □ Numbness □ Stiffness □ Weakness **Is your condition:** □ New □ Acute □ Chronic

Are you aware of your diagnosis: □ Yes □ No **Are you aware of your chance for recovery:** □ Yes □ No

Date of Injury/On set of Symptoms: ____/____/_____ **Do you have medical allergies:** □ Yes □ No If yes, please list: _____

Have you been hospitalized for your condition? □ Yes □ No If yes, date?: ____/____/_____

Have you had surgery for your condition? □ Yes □ No If yes, date?: ____/____/_____

Have you received previous treatment for this condition? □ Yes □ No If yes, date?: ____/____/_____

Describe Treatment Received: _____

Are you taking any medications?: □ Yes □ No If yes, please provide list: _____

_____

For this condition, have you ever had any of the following?: □ EMG □ MRI □ CAT Scan □ X-Ray □ Myelogram

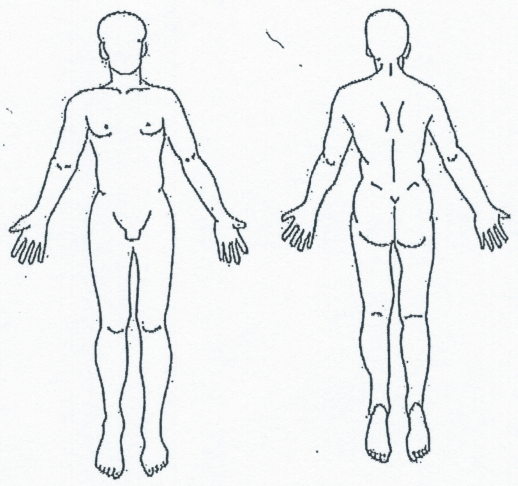
Are you presently treated or have you ever had any of the following medical conditions? (Check all that apply)

□Anemia
□ Arthritis/Swollen Joints
□Asthma/Emphysema
□Blood Clot/Emboli
□Bowel or Bladder Problems
□Bleeding Disorder
□Breathing Problems
□Cancer
□Chronic Lung Disease
□Diabetes
□Dizzy Spells
□Emotional/Psychological Problems
□Fainting Spells
□Fracture
□Gout
□Heart Trouble
□Headaches
□Hepatitis A B C
□High Blood Pressure
□HIV
□Implant
□Infectious Disease
□Neurological Condition
□Osteoporosis
□Pacemaker/Defibulator
□Are you pregnant?: □ Yes □ No
□Seizures
□Shortness of Breath/Chest Pain
□Sleeping Difficulties
□Stroke
□Thyroid Trouble/Goiter
□Total Joint Replacement
□Tuberculosis
□Varicose Veins
□Vision/Hearing Difficulties
□Other: _____

Recreational Activities: _____

Exercise: _Daily _Weekly **Smoking:** _Daily _Weekly **Alcohol Consumption:** _Daily _Weekly **Are you receiving Home Health?** ___Yes ___No

Are you a resident in a Nursing Home? ___Yes ___No **Are you receiving Hospice Care?** ___Yes ___No **Have you had therapy this year?** ___Yes ___No



BODY PAIN CHART

Please mark on the figure to the left.

↑ or↓ Radiating Pain **XXX** Spasm **ZZZ** Tenderness
////// Numbness/Tingling **0000** Ache/Pain

Is pain worse: ___ In the morning ___ During the day ___ At night ___ Constant

Does pain increase with specific movements or activities? ___ Yes ___ No

If yes, please describe: _____

What is your pain level? 0 = None 1-3 = Mild 4-7 = Moderate 8-10 = Severe

Circle a number: 0 1 2 3 4 5 6 7 8 9 10

What helps relieve your pain?: _____

I believe the above information is true and correct to the best of my knowledge.

_____

Patient Signature **Date**

Form Updated 2/21/11 KK

CrossRoads – *Patient Information Sheet*

We're glad to have you! *What made you choose US over another therapy provider?* (Mark all that apply)

☐ TV ☐ Radio ☐ Newspaper ☐ Friend ☐ Family ☐ Previous Patient ☐ Physician ☐ Other

Patient Name:_____ Nickname:_____
Last First MI

Phone: (____)____-____ (____)____-____ (____)____-____ Marital Status: ☐ Married ☐ Single
Home Cell Work ☐ Divorced ☐ Widowed ☐ Separated

Gender: ☐ M ☐ F DOB:____/____/____ SSN: ____-____-____ E-mail:_____

Address:_____ _____ ____ _____ _____
Street City State Zip County

Worker's Compensation? ☐ Y ☐ N Employer: _____ Date of Injury: ____/____/____

Motor Vehicle Accident? ☐ Y ☐ N State: _____ Date of Accident: ____/____/____

Is the patient a minor? ☐ Y ☐ N (If no, skip this section) Name of Guardian:_____
First MI Last

Guardian DOB: ____/____/____ Guardian SSN: ____-____-____ Guardian Phone: (____) ____-____

Guardian Address: _____ _____ _____ _____ _____
Street City State Zip County

PRIMARY Insurance Provider_____ Relationship to the Policyholder:_____

Policyholder Name:_____ DOB:____/____/____ SSN: ____-____-____

Policyholder Address (if different than above):_____ _____ ____ _____
Street City State Zip

Policyholder Phone: (____) ____-____ Employer:_____

Policy ID#:_____

Group #:_____

SECONDARY Insurance Provider:_____ Relationship to the Policyholder:_____

Policyholder Name:_____ DOB:____/____/____ SSN:____-____-____

Policyholder Address (if different than above): _____ _____ _____ _____
Street City State Zip

Policyholder Phone: (____) ____-____ Employer:_____

Policy ID#:_____ Group #:_____

EMERGENCY CONTACT: _____ Telephone #:_____

Consent to Treat/Privacy Policy: I hereby agree and give my consent to outpatient therapy treatment. It has been explained to me that therapy is not an exact science, and no guarantee has been made as a result of any treatment administered. I authorize release of any medical information needed to process my claim. I acknowledge that I have seen the *Notice of Privacy Practices*. I understand that I may ask questions about the *Notice of Privacy Practices* at any time. I hereby give my consent to release my personal health information to the following:

Name:_____ Name:_____

Patient/Parent/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____