Spokane Rehab & Pain Clinic, LLC
1315 N. Division St.
Spokane, WA 99202

Patient Information

Name:_____Date: _____

Birth Date:_____ □ Female □ Male □ Married □ Single

Contact Information: _____ _____

Home# Cell#

Can we leave a detailed phone message? □ Yes □ No

E-mail Address_____

Preferred Reminder Method: □ Call □ Text □ Email

Address: _____

Street Apt# City State Zip

Is patient on, or recently been on Home Health or Hospice? □ Yes □ No

Do you have any electrical implants (E.g., Pacemaker, defibrillator, pumps)? □ Yes

□ No

Person Responsible for Account – please check one: □ Self □ Guardian □ Spouse

□ Parent Was this due to: Auto Accident □ Yes □ No Work injury □ Yes □

No

Emergency Contact

Name:_____

Telephone #: _____

I authorize SPRC to discuss my account with the following people:

_____

How did you hear about us?

(Please be specific so we can show our appreciation.)

□ Friend/Family: _____

□ Community Print Media: _____

□ Internet Search □ Physician

□ Phonebook □ Drive by

□ Insurance company

□Other: _____

Insurance Information

Primary	Secondary
(Subscriber) Firs MI	(Subscriber) Firs MI
Birth date (mo/day/year) Relationship to	Birth date (mo/day/ Relationship to
Employe Insurance Co. & Phone	Employe Insurance Co. & Phone
SS# Subscriber Group	SS# Subscriber Group

Patient Agreements:

I understand that Spokane Rehab & Pain Clinic, LLC does their best to work within the confines of my insurance plan, however I am responsible for keeping track of the details of my claim including: required referrals or prescriptions, insurance authorizations, benefit limits, and use of benefits at other locations/therapies.
I authorize my insurance plan to make payments directly to Spokane Rehab & Pain Clinic, LLC.

I grant release of my medical history and other information about my treatment to third party payers and other health professionals.

I understand that if my insurance doesn't cover the billed amount I am responsible for the unpaid balance. I understand that if I have an unpaid balance with Spokane Rehab & Pain Clinic, LLC, a minimum monthly finance charge will be applied of $2.00 up to 1% of my end of the month balance. In case of default payment, I am responsible for any legal interest, collection costs and reasonable attorney's fees. There is a $25.00 return check fee on all unpaid checks to Spokane Rehab & Pain Clinic, LLC.

The information on the patient information page and medical history is correct to the best of my knowledge. I request and consent to receive treatment at Spokane Rehab & Pain Clinic, LLC.

Appointment Cancellation and No-Show Policy:

I understand that SRPC requires 24 hour notice prior to cancelling my appointment. If I do not comply with this policy or no-show for my appointment I am responsible for a potential no-show fee. I understand that two "No shows" may result in discharge from the program.

Notice of Privacy Practices Acknowledgement:

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that your *Notice of Privacy Practices* has been made available to me, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Name_____**Signature**_____**Date**_____

Medical History

Patient Name: _____
Date:_____
Primary Care Physician:_____

When is your next Doctor's appointment? _____
Please list other therapies you have had this year: _____

_____

Chief complaint/primary concern for treatment: _____

_____

1) If pain is not from a surgery or injury, when and how did it begin? _____

_____

2) Occupation: _____
3) History of Falls (month/year):_____
4) History of Trauma - Emotional or Physical (month/year): _____

_____

5) Do you have difficulty or pain with any of the following activities? (check all that apply)

_changing/maintaining position		_self-care	_house chores->	(inside/outside)
_remain standing upright	_standing	_hygiene	_sleeping	_up/down stairs
_remain seated	_sitting down	_dressing	_running	_reaching overhead
_carrying objects	_caregiving	_walking	_driving	_walking ½ mile
_pushing/pulling	_turning head	_lifting	_squatting	_food preparation

6) Please list all other major events that happened during these stages in your life: (include dates)
(Ex: traumatic events, severe sickness, surgeries, fractures, car accidents, divorce, death, child birth/C-section, etc.)

Age 0-20_____

Age 20-40_____

Age 40-60_____

Age 60+

Have you had history or difficulty with any of the following? (please check all that apply, and specify)

_ Alzheimer's	_Concussion/Traumatic Brain Injury	_ Meniscal Problems (Torn, Thin) Right/Left
_Heart problems/cardiac	_Tinnitus (ringing in ear) Right/Left	_ Skin Issues (rashes, wounds, scars) Location _____
_Brain Fog/Memory Issues	_Earaches Right/Left	_Osteoporosis/Osteopenia
_Cerebral Vascular Accident (CVA)	_Dizziness/ Balance Issues In what position?_____	_Lung Issues (Asthma, COPD, Bronchitis)
_Current Infection_____ _____	_Plantar Fasciitis/ Foot Pain Right / Left	_Sciatica Right/ Left _ Tailbone Pain
_ Diabetes Type 1/ Type 2	_Orthotics/Heel Lifts Right/ Left	_Circulation Problems/ Raynaud's Location_____
_Fibromyalgia	_Leg Length Discrepancy: Which is longer? Right/ Left	_Allergies (Food, Latex, Environmental) _____
_Fracture or Suspected Fracture Where_____	_Joint Pain: Where?	_Chronic Fatigue Syndrome
_High Blood Pressure	_Incontinence of Bowel/ Bladder	_Depression/ Anxiety
_Cancer _____	_Constipation	_Sinus Problems
_Autoimmunity _____	_Headaches: Migraine/ Tension	_Digestive/ Stomach Problems
_Obesity/Weight Gain/Loss	_Hypermobility/Double Jointed Where_____	_Eating Issues (Disorder/ Texture) _Dental Problems/TMJ
_Osteoarthritis/Rheumatoid arthritis Where_____	_Muscle Weakness Location_____	_Sleep Difficulties
_Parkinson's/Tremors	_Coordination Issues/Sensory Issues (Sound, Light, Texture)	_Other_____ _____

Have you had MRI's or X-Rays? Please list all areas and year_____

_____

_____

Have you had Surgeries? Please include type and dates_____

_____

_____

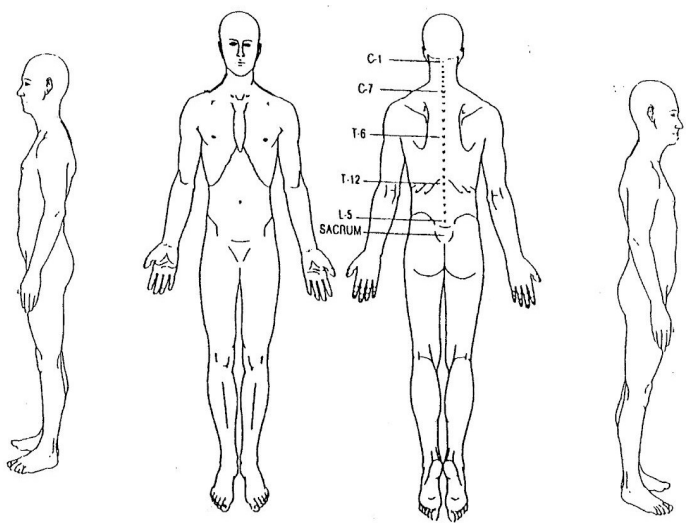
_____

What medications are you taking? (Prescription, over the counter, vitamins, herbals). Do you have a medication list we can copy?

Please list your goals for therapy. What activities would you like to be able to do again without pain?

Are there any other concerns you would like us to know about or address? _____

7) Please mark on the bodies where you feel **P**ain, **T**ightness, **N**umbness/**T**ingling.



8) Please list your pain areas and choose the best description for your pain.

Rate your pain 0-10 (10 being the worst)

Area	**Area**	**Area**
_____	_____	_____

Rate your pain 0-10 (10 being the worst)

Worst:	_____	_____	_____
Current:	_____	_____	_____
Best:	_____	_____	_____

Description			
Dull/Achy:	____	____	____
Burning:	____	____	____
Sharp:	____	____	____
Throbbing:	____	____	____
Shooting:	____	____	____
Numbness/Tingling:	____	____	____
Constant:	____	____	____
Intermittent:	____	____	____

Is the pain worse in: _AM _PM

Dominant hand Left Right **Required for Medicare patients:** Height:_____Weight: _____

Daily Nutrition:

Water intake: (cups)_____ Sugar intake: (grams) _____

Caffeine intake: (cups)_____ Alcohol: (Cups) _____

Do you smoke? No Yes (If yes, how much per day?)_____

Current exercise program? _____

Have you had any loss of strength recently? When and where? _____