

**Patient Information**

Social Sec #: \_\_\_\_\_

Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone/Pager #: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Soc Sec #: \_\_\_\_\_ Spouse's D.O.B: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Employer's Phone #: \_\_\_\_\_

Name of Nearest Relative (Not Your Spouse): \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred you to our office?: \_\_\_\_\_

Is your visit due to an accident?:  Yes  No If Yes,  Auto  Work  Sport

Briefly Describe Your Symptoms: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List other doctor(s) seen for this condition: \_\_\_\_\_

Medical History (of any of the following are relevant to your medical history, please check accompanying box):

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Polio               | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Sinus Trouble       |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Convulsions        | <input type="checkbox"/> Nervousness     | <input type="checkbox"/> Back aches          |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Numbness            |
| <input type="checkbox"/> Heart Trouble       | <input type="checkbox"/> Concussion         | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Arthritis           |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> German Measles  | <input type="checkbox"/> Venereal Disease    |

Describe any operations you've had and the date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been treated by a physician for any health condition in the last year?  Yes  No

Describe Condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Are you now taking any medication?  Yes  No What kind?: \_\_\_\_\_

Are you allergic to any medication?  Yes  No What kind?: \_\_\_\_\_

Are you pregnant?  Yes  No Date of last menstrual period: \_\_\_\_\_

Do you have health insurance?  Yes  No Insurance Company: \_\_\_\_\_

Phone: \_\_\_\_\_ I.D. #: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the Insurance Company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse and to issue remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment, it is my understanding that my credit may be checked if Definitive Rehab & Pain Management extends credit to me and I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable, unless prior arrangements are made. I hereby authorize the doctors at Definitive Rehab & Pain Management and whomever they may designate as their assistant to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is correct. I authorize and assign the direct payment by an insurance company obligated to make payment based on the charges made for your services.

Patient's (Parent or Guardian's) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

**“WARNING CONFIDENTIAL”**

NOTE TO PATIENT: THIS FORM MUST BE SIGNED FOR THE RELEASE OF MEDICAL RECORDS BY YOUR OTHER HEALTHCARE PROVIDERS.

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

The undersigned patient/guardian states the following:

TO ANY PHYSICIAN, HOSPITAL, CLINIC OR THEIR REPRESENTATIVE:  
YOU ARE HEREBY AUTHORIZED AND REQUESTED TO FURNISH THE ABOVE  
NAMED PATIENT'S MEDICAL RECORDS TO:

DEFINITIVE REHAB & PAIN MANAGEMENT  
307 E. Ovilla Road, Suite 600, Red Oak, Texas 75154  
Phone: 972-576-2920 Fax: 972-617-3930

Please furnish the medical records indicated below:

\_\_\_\_\_ ALL

\_\_\_\_\_ ALL FROM: \_\_\_\_\_ TO: \_\_\_\_\_

\_\_\_\_\_ SPECIFIC REQUEST: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A photocopy of this authorization is to be considered as valid as the original.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**Medical History**

General Medical Problems: Please circle any/all that apply:

Stomach problems, Ulcer etc... Gout, Sexual Difficulties, Bowel or Bladder Problems, Depression, Loss of weight Other \_\_\_\_\_

Have you been in the hospital with other medical problems? Yes \_\_\_ No \_\_\_

Please describe: \_\_\_\_\_

Please list current medications over the counter and prescribe:

\_\_\_\_\_  
\_\_\_\_\_

**History**

**Age**

**Medical Problems**

Father: Alive or Deceased \_\_\_\_\_

Mother: Alive or Deceased \_\_\_\_\_

Siblings: Alive or Deceased \_\_\_\_\_

**Social History**

Do you smoke? Yes \_\_\_ No \_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_

Do you drink alcoholic beverages? Yes \_\_\_ No \_\_\_ How much/Often? \_\_\_\_\_

**Employment History**

Are you employed? Yes \_\_\_ No \_\_\_ F/T \_\_\_ P/T \_\_\_ Full duty \_\_\_ Light Duty \_\_\_\_\_

If you are not working when did you last work? \_\_\_\_\_

If you are not working, which applies to you? Medical leave Quit Retired  
Fired Position terminated other (specify) \_\_\_\_\_

Has the pain affected your ability to work? Yes? \_\_\_ No \_\_\_, how? \_\_\_\_\_

Please check the statements that apply to you.

\_\_\_ I am receiving workman's comp. \_\_\_ I have received work comp settlement

\_\_\_ I have pending legal action. Attorney Name \_\_\_\_\_

\_\_\_ I have received a person injury settlement. \_\_\_ I have applied for SSDI

\_\_\_ I have received an impairment or disability rating.

Do you have any work restrictions? Yes \_\_\_ No \_\_\_

Explain:

\_\_\_\_\_  
\_\_\_\_\_

Occupation \_\_\_\_\_ Left handed or Right \_\_\_\_\_

**Present History**

Approximately what date did you present pain start? \_\_\_\_\_

What event cause the pain (accident, surgery, unknown etc..) \_\_\_\_\_

Was your injury: Work related \_\_\_ MVA \_\_\_ Other (specify) \_\_\_\_\_

Have you ever had similar pain before? Yes \_\_\_ No \_\_\_

Have you had a prior problem in this area? \_\_\_\_\_

Describe what happened.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What other doctors have treated you for this condition?

\_\_\_\_\_  
\_\_\_\_\_

Test

	Y/N	DATE	Location
EMG/NCV	_____	_____	_____
CT SCAN	_____	_____	_____
MRI	_____	_____	_____
MYLEOGRAM	_____	_____	_____
BONE SCAN	_____	_____	_____
DISCOGRAM	_____	_____	_____

Present medications for pain and symptom control: \_\_\_\_\_

\_\_\_\_\_

Have you been in the hospital for your condition? Yes \_\_\_ No \_\_\_

Have you had epidural, trigger point or facet joint injections? Yes \_\_\_ No \_\_\_

Previous Physical Therapy? Yes \_\_\_ No \_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_

Describe the degree of pain you experience:

BARELY NOTICEABLE MILD MODERATE SEVERE UNBAREABLE

Is the pain constant, Intermittent or occasional? \_\_\_\_\_

How many hours per day do you have pain? (If not every day estimate how many hours per week or month) \_\_\_\_\_

How many weeks, months or years have you been disabled by pain? \_\_\_\_\_

Do you consider yourself to be disabled? Yes \_\_\_ No \_\_\_\_\_

What activities make the pain worse:

- |  |  |
|--|--|
| <input type="checkbox"/> During Exercise | <input type="checkbox"/> Bending Backwards |
| <input type="checkbox"/> After Exercise  | <input type="checkbox"/> Coughing          |
| <input type="checkbox"/> Sitting         | <input type="checkbox"/> Sneezing          |
| <input type="checkbox"/> Standing        | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Walking         |  |
| <input type="checkbox"/> Bending Forward |  |

What reduces your pain?

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Lying down   | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Sitting      | <input type="checkbox"/> Pain Pills       |
| <input type="checkbox"/> Standing     | <input type="checkbox"/> Muscle Relaxants |
| <input type="checkbox"/> Walking      | <input type="checkbox"/> Aspirin          |
| <input type="checkbox"/> Manipulation | <input type="checkbox"/> Other _____      |

Unusual symptoms related to your pain (i.e. Nausea, Dizziness, Fatigue, Headaches, etc.) \_\_\_\_\_

# Initial Pain Assessment Tool

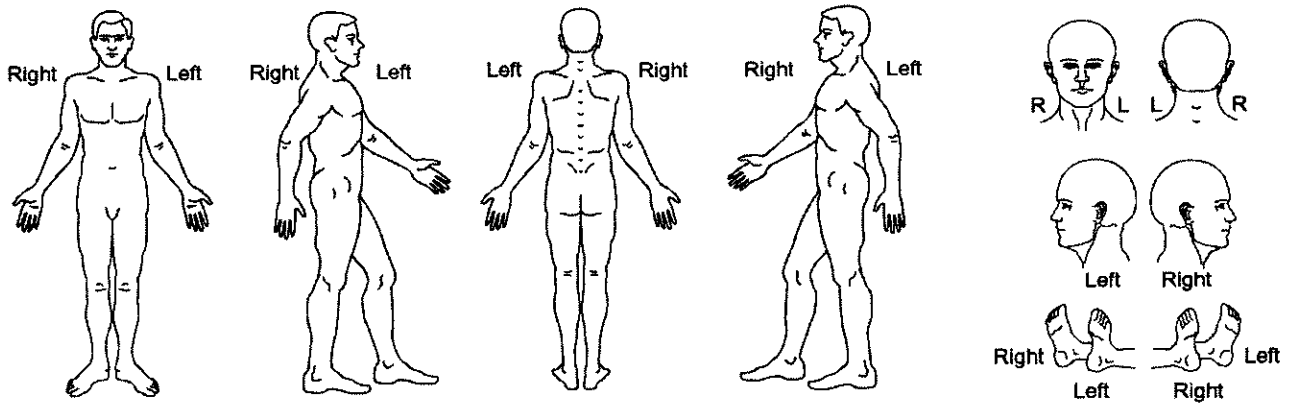
Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_ Age: \_\_\_\_\_ Room: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Physician: \_\_\_\_\_

Nurse: \_\_\_\_\_

## I. Location: Patient or nurse marks drawing



II. Intensity: Patient rates the pain. Scale used: \_\_\_\_\_

Present: \_\_\_\_\_

Worst pain gets: \_\_\_\_\_

Best pain gets: \_\_\_\_\_

Acceptable level of pain: \_\_\_\_\_

III. Quality: (Use patient's own words, e.g., prick, ache, burn, throb, pull, sharp)

\_\_\_\_\_

IV. Onset, duration, variations, rhythms: \_\_\_\_\_

\_\_\_\_\_

V. Manner of expressing pain: \_\_\_\_\_

\_\_\_\_\_

VI. What relieves the pain? \_\_\_\_\_

\_\_\_\_\_

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

This notice takes effect on \_\_\_\_\_ and remains in effect until we replace it.

**1. OUR PLEDGE REGARDING MEDICAL INFORMATION**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive from our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

**2. OUR LEGAL DUTY**

*Law Requires Us to:*

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

*We Have the Right to:*

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

*Notice of Change to Privacy Practices:*

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

**3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing us.

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purpose.

**FOR HEALTH CARE OPERATIONS:** We may use / disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

## **NOTICE OF PRIVACY PRACTICES**

**ADDITIONAL USES AND DISCLOSURES:** In addition to using and disclosing your medical information for treatment, payments, and health care options, we may use and disclose information for the following purposes.

**Facility Directory:** Unless you notify us that you object, the following medical information about you will be placed in our facilities: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

**Notification:** Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about following someone to pick up medicine, supplies, x-ray or medical information for you.

**Disaster Relief:** Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

**Fundraising:** We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

**Research in Limited Circumstances:** Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

**Funeral Director, Coroner, Medical Examiner:** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

**Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

**Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with law enforcement officials concerning the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

**Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

**ACKNOWLEDGEMENT OF RECEIPT**

By my signature below, I acknowledge that I have received the Practice's *Notice of Privacy Practices* on or prior to any service being provided to me by the Practice following April 14, 2003 and consent to the use and disclosure of my medical information as set forth herein.

**SIGNATURES:**

Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

If Legal Representative, relationship to Patient: \_\_\_\_\_

I hereby request the following restrictions on the use of my information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Amended Appointment Cancellation and No Show Policy**

**In an effort to professionally and efficiently serve all Definitive Rehab & Pain Management patients, Definitive Rehab will enforce appointment cancellations and no shows (i.e., failing to show-up for or call and cancel an appointment) as follows:**

1. Patients must provide no less than 24-hours notice of any appointment cancellation.
2. A patient who fails to provide at least 24-hours notice of an appointment cancellation or no shows for an appointment will be charged \$35 for his/her failure to attend the scheduled appointment.
3. Patients who (a) in violation of Policy 1, described above, cancel or no show for (1) two consecutive appointments or (2) any series of appointments Definitive Rehab determines to be unreasonable or (b) are excessively tardy for any series of appointments we determine to be unreasonable will be moved to "walk-in only" status.

"Walk-in only" patients will not be allowed to schedule appointments with Dr. Rudder or Physical Therapy. Such patients will be given a time period in which it is recommended that they come in, although they are free to come in at their convenience. It is recommended that walk-in only patients call before coming in on the day that they intend to come in, regardless of whether they have been given a recommended time.

We will gladly serve all walk-in only patients to the best of our ability. However, such patients must understand that scheduled patients will be given first priority. We cannot guarantee that in all instances walk-in only status patients will be seen every time they come in or within a reasonable time period. We do promise, however, to give walk-in only patients a best estimate of whether they can be seen, the time they may be seen, and the probable wait time when they call, upon their arrival, and during their wait, as appropriate.

Walk-in only patients who attend 3 consecutive appointments can request that they be removed from walk-in only status.

Thank you for understanding and for your cooperation.

**Please sign below to acknowledge that you have read and understand the above described policy.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Date: \_\_\_\_\_

I \_\_\_\_\_ give \_\_\_\_\_ permission to discuss any  
medical issues relating to my treatments here at Definitive Rehab and Pain Management

\_\_\_\_\_ \* release prescriptions pending for me here at Definitive Rehab and Pain Management

Patient signature: \_\_\_\_\_

Witness \_\_\_\_\_

**\*(Please check if release of prescription is wanted)**

**Additional Person:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_