the BROTHERS of MERCY

THE CHARITY OF CHRIST URGES US ON

THE RUSSELL J. SALVATORE OUTPATIENT REHABILITATION CLINIC

Name: First: _____ M.I.: _____ Last: _____

Address: _____ State: _____ Zip Code: _____

City: _____ DOB: _____ Birthplace: _____

Phone- Day #: _____ Gender: MALE / FEMALE Race: _____

Eve #: _____ Religion: _____ Citizenship (if other than US): _____

Cell #: _____ Language: _____

Social Security #: _____ Marital Status: _____ Occupation: _____

Email Address: _____ Employer: _____

Primary Care Physician/ Attending: _____
FIRST INITIAL LAST NAME PRACTICE ADDRESS

Referring Physician (if different): _____
FIRST INITIAL LAST NAME PRACTICE ADDRESS

How did you hear about us?: _____

☐ SEND BILLING STATEMENTS DIRECTLY TO PATIENT Type of Service requested: ☐ PT ☐ OT ☐ ST

EMERGENCY & BILLING CONTACTS

Primary Contact Person: Phone: Day #: _____

First Name _____ ☐ CONTACT REGARDING MEDICAL / IN A MEDICAL EMERGENCY Eve #: _____

Last Name _____ ☐ REGARDING INSURANCE ISSUES Cell #: _____

Relationship _____ ☐ REGARDING BILLING ISSUES ☐ POA ☐ HCP

Address: _____ ☐ COPY OF PAPERWORK PROVIDED/ON FILE

City: _____ State: _____ Zip Code: _____

Email Address: _____

2nd Contact Person: Phone: Day #: _____

First Name _____ ☐ CONTACT REGARDING MEDICAL / IN A MEDICAL EMERGENCY Eve #: _____

Last Name _____ ☐ REGARDING INSURANCE ISSUES Cell #: _____

Relationship _____ ☐ REGARDING BILLING ISSUES ☐ POA ☐ HCP

Address: _____ ☐ COPY OF PAPERWORK PROVIDED/ON FILE

City: _____ State: _____ Zip Code: _____

Email Address: _____

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Name: First: _____ M.I.: _____ Last: _____

Reason for therapy: _____

Date symptoms started/ recent surgery(s): _____

Any recent Imaging for this problem? _____

Have you had treatment for this condition previously at another location? _____

Previous surgeries/ hospitalizations: _____

Have you fallen in the last 6 months? _____

My goal for therapy: _____

Is this related to Workers Compensation/No Fault case or have you had a WC/NF claim in the past: Y / N (CIRCLE) effected/impacted area: _____

Other medical conditions (CHECK ALL THAT APPLY) Are you currently pregnant: ☐ YES ☐NO

☐ CANCER	☐ HIGH BLOOD PRESSURE	☐ FIBROMYALGIA	☐ NAUSEA/ VOMITING
☐ DIABETES	☐ RHEUMATOID ARTHRITIS	☐ OSTEOPOROSIS	☐ HEADACHES
☐ STROKE	☐ OSTEOARTHRITIS	☐ CHRONIC PAIN	☐ UNEXPLAINED WGT LOSS/GAIN
☐ LUPUS	☐ CHRONIC FATIGUE	☐ COPD	☐ NEUROLOGICAL DISEASE
☐ ATRIAL FIB	☐ HEART DISEASE/ ANGINA	☐ ASTHMA	☐ DIZZINESS
☐ PACE MAKER	☐ OPEN HEART SURGERY	☐ KIDNEY DISEASE	☐ DIFFICULTY SWALLOWING
☐ CHF	☐ HEART ATTACK	☐ UTI	☐ NUMBNESS/TINGLING
☐ ANXIETY	☐ THYROID ISSUES	☐ BLOOD CLOTS	☐ SHORTNESS OF BREATH
☐ DEPRESSION	☐ SEIZURES	☐ GERD	☐ SKIN ULCERS/ WOUNDS
☐ STD'S	☐ HX OF TOBACCO/DRUG USE	☐ ALCOHOL ABUSE	☐ BOWEL/BLADDER INCONTINENCE

☐ OTHER:(specify) _____

Allergies: _____

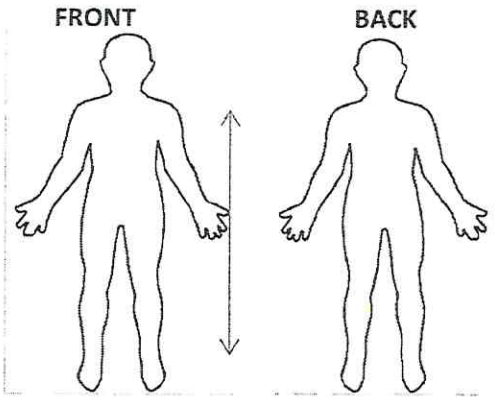
Current Medications: _____

Pain: (INDICATE AREA(S) OF PAIN WITH AN "X" IN THE DIAGRAM BELOW)

My pain is: (CIRCLE)

Occasional (0-25%) Intermittent (25-50%)

Frequent (50-75%) Constant (75-100%)



***IT IS FACILITY POLICY TO PROVIDE CARDIOPULMONARY RESUSCITATION (CPR) FOR ALL PATIENTS UNLESS THEY HAVE A VALID DNR (DO NOT RESUSCITATE ORDER). WE MUST HAVE A COPY ON FILE TO HONOR YOUR DNR WISHES

DO YOU HAVE A DNR? ☐ YES ☐NO

SIGNATURE: _____ DATE: _____