Rue &
Primavera
Occupational, Physical & Hand Therapy

Patient Intake Packet EMG or Nerve Conduction Study

Date: _____Email Address: _____

Patient Name: _____SSN:_____

Occupation Title:_____Company Name:_____

Last First Middle

Date of Birth: ____/____/___Age:____ Gender: M_____F_____ Cell: (____)_____Home: (____)_____

Mailing Address: _____

Street City Zip

In case of an emergency, whom should we contact? _____

Phone: _(_____)_____ Relationship to patient: _____

Primary Insurance Information

Insurance Name: _____Phone: (_____)_____

Policy ID#:_____Group#:_____ Sponsors Name:_____

Sponsors DOB:_____ Sponsor SSN (Tricare patients only):_____

Secondary Insurance Information

Insurance Name: _____Phone: (_____)_____

Policy ID#:_____Group#:_____ Sponsors Name:_____

Sponsors DOB:_____ Sponsor SSN (Tricare patients only):_____

Work Related Incident

DOI: ____/____/_____Company Name:_____Company Phone:(_____)_____

Company Address: _____

Street City Zip

Auto/PIP Related Incident

Insurance Name:_____ID #:_____

Claim #:_____Is PIP available?:_____

Initial ONLY if updating information on packet.

Updated Information Date:____/_____/_____ Patient Initials:_____

Informed Consent to treat for EMG or Nerve Conduction Study

Response to physical and occupational therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Rue and Primavera does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical and/or occupational therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

I, the undersigned patient or patient's representative, request admission to Rue and Primavera Rehabilitation for care and treatment. I certify that the information given is correct. I am aware that the practice of Rue and Primavera Rehabilitation is not an exact science and acknowledge that no guarantees or promises have been made as to the result of treatment of examination.

RELEASE OF MEDICAL INFORMATION/ FINANCIAL AGREEMENT/ ASSIGNMENT OF BENEFITS/ MEDICARE CERTIFICATION/ PERSONAL VALUABLES: I authorize Rue and Primavera Rehabilitation to release any information necessary to facilitate the processing of health care claims, and audit of payments relative to this care. I consent to the release of any information as needed to my referring and primary physician and to other health facilities or agencies as I direct or as required by law.

Signature_____Date_____

Joint Notice of Privacy Practices Acknowledgment

We keep a record of the health care services we provided you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name Relationship to patient (parent, legal/personal representative)

Release of Medical Information

Please include the names of persons with whom we are allowed to discuss your medical and billing information (please include other medical facilities that you may need us to send information to other than your referring provider):

_____ _____

Name Relationship

_____ _____

Name Relationship

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Past Medical History

Patient Name: _____ Todays Date:____/____/____
Date of Injury/Onset:__/____/____ Date of Next Doctors appointment:___/____/____
Have you ever had these symptoms before? Yes ☐ No ☐
Check which apply to your current condition:
☐Work-related injury ☐recurrence of previous injury ☐Athletic /recreational injury ☐Motor vehicle accident
☐injury related to lifting ☐injury related to falling ☐Cause unknown ☐other: _____

Have you had a related surgery? Yes☐ No☐
Any allergies? Yes ☐ No☐ If yes please list all known allergies:_____

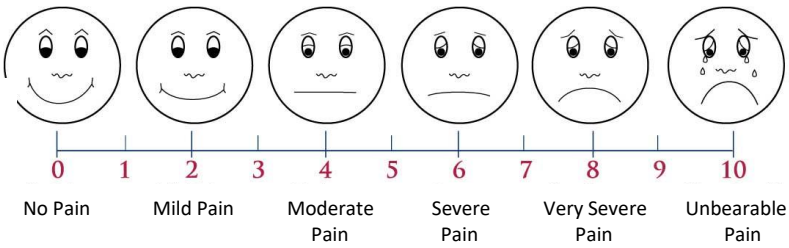
Have you fallen two or more times in the past 12 months? Yes ☐ No ☐
Are you here today because of a fall? Yes ☐ No ☐
Do you have any problems with walking or balance? Yes ☐ No ☐
Do you have any stressors in your life at the moment? Yes ☐ No ☐
Do you suffer from PTSD or depression? Yes ☐ No ☐

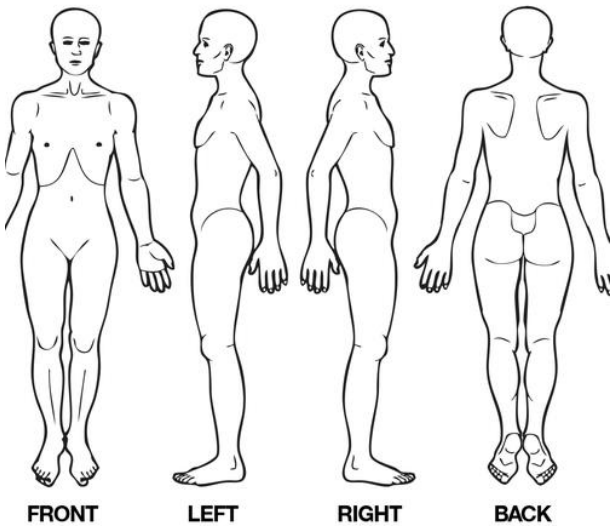
Do you have, or have you had any of the following:	Yes	No		Yes	No
Diabetes (Type 1 or Type2)			Alzheimer's/Dementia		
Chest Pain/Angina			Osteoarthritis		
High Blood Pressure			Osteoporosis		
Heart Disease			Rheumatic Arthritis		
Asthma/ Breathing Difficulties			Seizures		
Stroke			Metal Implants		
Pacemaker			Dizziness/ Fainting		
Cancer			Fracture		
Urine Leakage			Surgeries		
Bowel/ Bladder Abnormalities			Smoking		
Ringing in the ears			Other		

If you answered yes to any of the items on the right please explain and provide dates below. Include any other pertinent information regarding your medical history.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

First: Please shade in any areas of pain, discomfort or concern.
Second: Using the Scale Below, rate each area of pain and mark the appropriate pain number next to the shaded area.





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Current Medication List

(This includes prescriptions, over-the- counter, Herbals, vitamins, mineral/dietary and nutritional supplements.)

If you are not currently taking any medications or supplements please write that you are not taking any.

Current Medication / Supplement	Dosage	Frequency	Start Date	Stop Date
1.				
2				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

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