

# Confidential Medical History/Evaluation



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

How did you hear about ProCare? \_\_\_\_\_

## Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ M/F Age: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_-\_\_\_\_ Home phone#: \_\_\_\_\_ Cell phone#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer address: \_\_\_\_\_ Work phone#: \_\_\_\_\_

## Spouse Information

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_-\_\_\_\_

Employer (If insurance subscriber): \_\_\_\_\_ Phone#: \_\_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

Have you received **Home Health** treatment for this or any other condition in this calendar year? YES \_\_\_ NO \_\_\_

If YES- what agency provided the services and for how long were you seen? \_\_\_\_\_

Is this condition the result of a work related injury? Y N

Is this condition related to an auto accident? Y N

Is this condition related to a motorcycle accident? Y N

Is this condition related to a personal accident? Y N

Is this condition the result of a school athletic injury? Y N

If yes to any of the above, have you retained an attorney? Y N

Attorney Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number \_\_\_\_\_

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to ProCare Health Systems, Inc. regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred equaling 25% of my balance due.

Patient/parent/guardian signature: \_\_\_\_\_

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

**Medical History**

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Surgery: \_\_\_\_/\_\_\_\_/\_\_\_\_

Area of injury/condition: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Current Symptoms: Pain Numbness Stiffness Weakness Condition: New Acute Chronic

List any/all medications you are currently taking: \_\_\_\_\_

Are you allergic to any medications?: \_\_\_\_\_

Past surgeries: \_\_\_\_\_

Have you had any diagnostic or rehabilitative services for this injury (MRI, x-ray, etc): \_\_\_\_\_

Do you have any of the following?

	YES	NO
Asthma, bronchitis, or emphysema.....	_____	_____
Shortness of breath/chest pain.....	_____	_____
Coronary heart disease.....	_____	_____
Do you have a pacemaker.....	_____	_____
High blood pressure.....	_____	_____
Heart attack/heart surgery.....	_____	_____
Stroke/TIA.....	_____	_____
Blood clot/emboli.....	_____	_____
Epilepsy/seizures.....	_____	_____
Thyroid trouble/goiter.....	_____	_____
Anemia.....	_____	_____
Infectious disease.....	_____	_____
Diabetes.....	_____	_____
Cancer or chemo/radiation.....	_____	_____
Arthritis/swollen joints.....	_____	_____
Osteoporosis.....	_____	_____
Varicose veins.....	_____	_____
Gout.....	_____	_____
Sleeping difficulties.....	_____	_____
Emotional/psychological problems.....	_____	_____
Bowel of bladder problems.....	_____	_____
Severe/frequent headaches.....	_____	_____
Vision/hearing difficulties.....	_____	_____
Dizziness of faintness.....	_____	_____
Are you pregnant?.....	_____	_____
Smoking	Daily_____	Weekly_____
Alcohol consumption	Daily_____	Weekly_____

Pain when performing the following activities?

	Mild	Moder	Severe	Unable
Bending.....	_____	_____	_____	_____
Care for infirm family.....	_____	_____	_____	_____
Carrying groceries.....	_____	_____	_____	_____
Change pos (sit to stand)...	_____	_____	_____	_____
Climbing stairs.....	_____	_____	_____	_____
Driving.....	_____	_____	_____	_____
Extended computer use....	_____	_____	_____	_____
Feeding (self).....	_____	_____	_____	_____
Household chores.....	_____	_____	_____	_____
Kneeling.....	_____	_____	_____	_____
Lifting children.....	_____	_____	_____	_____
Lifting.....	_____	_____	_____	_____
Pet care.....	_____	_____	_____	_____
Reading (concentration)...	_____	_____	_____	_____
Self care- bathing.....	_____	_____	_____	_____
Self care- dressing.....	_____	_____	_____	_____
Self care- shaving.....	_____	_____	_____	_____
Sexual activities.....	_____	_____	_____	_____
Sleep.....	_____	_____	_____	_____
Sitting (prolonged).....	_____	_____	_____	_____
Standing (prolonged).....	_____	_____	_____	_____
Walking.....	_____	_____	_____	_____
Yard work.....	_____	_____	_____	_____
Sports	_____	_____	_____	_____
Recreational Activities	_____	_____	_____	_____
Exercise	Daily_____	Weekly_____		

Other Medical Conditions \_\_\_\_\_

Are you aware of your diagnosis? YES\_\_\_\_ NO\_\_\_\_

Are you aware of your prognosis? YES\_\_\_\_ NO\_\_\_\_

Have you had physical/occupational therapy for this or any other injury/condition within the past year? If yes, please list dates and number of visits: \_\_\_\_\_