PATIENT INFORMATION

NAME_____DATE OF BIRTH_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____

OCCUPATION_____EMPLOYER_____ _____

WORK ADDRESS_____CITY_____STATE_____ZIP_____

WORK PHONE_____ E-MAIL ADDRESS_____

CELL PHONE #_____ REFERING MD_____

PCP_____HOW DID YOU HEAR ABOUT US?_____

EMERGENCY DATA

IN CASE OF EMERGENCY CONTACT:

NAME_____ PHONE NUMBER_____

ADDRESS_____ CITY_____STATE_____ ZIP_____

RELATIONSHIP_____

INSURANCE DATA

NAME OF INSURANCE COMPANY_____

POLICY NUMBER_____SUBSCRIBERS NAME/DOB_____

WAS INJURY DUE TO AN AUTO OR WORKERS COMP ACCIDENT?
IF YES, PLEASE FURNISH THE FOLLOWING.

DATE OF INJURY_____ FILE CLAIM NUMBER_____

INSURANCE COMPANY_____

ADDRESS TO SEND BILLS_____CITY_____STATE_____ZIP_____

CLAIMS ADJUSTERS NAME_____PHONE NUMBER_____

PRE-CERT CO._____PHONE NUMBER_____

I HEREBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO MOTIONATOMY , FOR SERVICES RENDERED.
I HEREBY AUTHORIZE MOTIONATOMY TO RELEASE (OR OBTAIN) INFORMATION REGARDING MY OCCUPATIONAL THERAPY EVALUATION AND TREATMENT AND RELATING BILLING INFORMATION TO (FROM) MY ATTORNEY, OR INSURANCE CARRIER FOR PURPOSES OF PROCESSING THIS CLAIM. **WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELLED WITHOUT 24HR NOTICE.**

SIGNATURE_____DATE_____

Occupational Therapy New Patient Worksheet

Name:_____ MRN:_____ Age:_____ Today's Date:_____

1. When did current symptoms start?_____

2. What was the cause of your pain or symptoms?

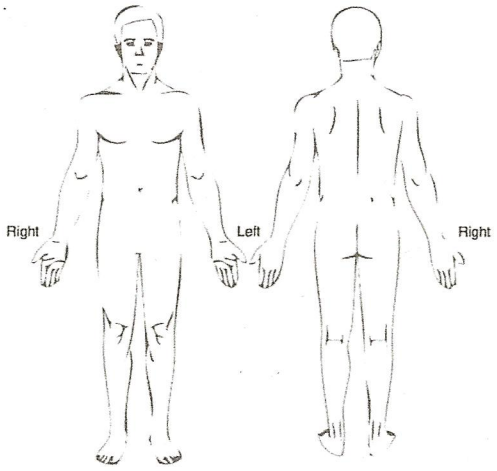
_____

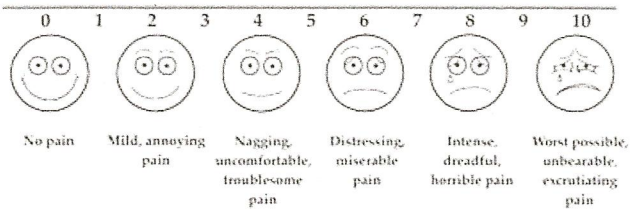
_____

3. Are your symptoms related to an injury? ☐Yes ☐No
   If yes, please give date of injury_____

4. Have you had surgery for this problem? ☐Yes ☐No
   If applicable: Date of surgery:_____

5. Mark areas where you're having pain with an **X**.
   Mark areas where you're having numbness/tingling with an **O**.





6.Using the scale above, place a **C** for **current** pain level and **W** for **worst** pain level in the last 30 days.

7.check the words that best describe your pain/symptoms.
☐ constant ☐ intermittent ☐ aching ☐ burning ☐ dull
☐ sharp ☐ stabbing ☐ numb ☐ tingling ☐ shooting
☐ sore ☐ throbbing ☐ other_____

8.What makes your pain worse?
☐ at rest ☐ lying down ☐ sitting ☐ standing ☐ moving
☐ walking ☐ stair climbing ☐ lifting ☐ reaching ☐ bending
☐ twisting ☐ coughing/sneezing ☐ other_____

9. What makes your pain better?
☐ lying down ☐ rest ☐ sitting ☐ heat ☐ moving
☐ walking ☐ exercise ☐ stretching ☐ heat ☐ ice
☐ medication ☐ massage ☐ compression ☐ elevation
other, explain_____

10. Please mark your **pre-injury** level of function.

1% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

11. Please mark your **present** level of function.

1% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

12. What medications are you taking?

Anti-inflammatory_____

Muscle relaxers_____

Pain Medications_____

Other Medications_____

13. Check any that apply to **your** medical history.

☐ Heart problems	☐ Pacemaker	☐ High Blood Pressure
☐ Stroke/TIA	☐ Seizures	☐ Lung problems
☐ Diabetes	☐ Cancer	☐ Infectious Disease
☐ Arthritis	☐ Osteoporosis	☐ Hernia
☐ Metal implants	☐ Anemia	☐ Thyroid problems
☐ Emotional/Psych	☐ Bowel/Bladder	

Surgeries_____

Allergies_____

14. Check any of the following you have had for this problem.
☐ Physical Therapy ☐ Occupational Therapy ☐ X-ray
☐ MRI ☐ Chiropractor ☐ Blood work ☐ Massage Therapy
☐ CT Scan ☐ Acupuncture ☐ EMG or nerve conduction.

15. Are you working now?
Occupation:_____
Employer:_____

16. Rate your overall health:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

17. Living Situation- I live: ☐ alone ☐ with spouse ☐ with son
☐ with daughter ☐ with parents ☐ with caregiver ☐ other

17. Home Environment:
1 - 2 - 3 Story: ☐ home ☐ condo/townhome ☐ apartment
☐ mobile home With - ☐ stairs ☐ ramp

18. Please provide your goals and expectations for therapy:

_____

_____

Signature:_____