



Name: _____ DOB: _____ Referring MD: _____
 Address: _____ City: _____ ST: _____ Zip: _____
 SSN: _____

Marital Status: Married Single Divorced

Primary Insurance Company: _____

Is this injury work related? Yes No Employer: _____

Chief Complaint: _____

List any/all medications you are currently taking: _____

Known allergies: _____

List any/all surgeries you've had: _____

Have you had any diagnostic or rehabilitative services for this injury? Please list: _____

Do you have any of the following:

	Yes	No	How did your pain start?	
Asthmas, Bronchitis or Emphysema	___	___	___ Suddenly	___ Pulling
Shortness of Breath/Chest Pain	___	___	___ Gradually	___ Injured at work
Coronary Heart Disease	___	___	___ Lifting	___ Bending
Heart Attack/Surgery	___	___	___ No Reason	___ Other
Stroke/TIA	___	___	What activities make the pain worse?	
Blood Clot/Emboli	___	___	___ Exercise (during)	___ Bending forward
Epilepsy/Seizures	___	___	___ Exercise (after)	___ Bending back
Thyroid Trouble/Goiter	___	___	___ Sitting	___ Coughing
Anemia	___	___	___ Walking	___ Sneezing
Infectious Disease	___	___	What reduces the pain?	
Diabetes	___	___	___ Lying down	___ Medications
Cancer or Chemo/Radiation	___	___	___ Sitting	___ Injections
Arthritis/Swollen Joints	___	___	___ Standing	___ Muscle relaxants
Osteoporosis	___	___	___ Walking	___ Other
Varicose Veins	___	___	When did this pain start? _____	
Gout	___	___		
Sleeping Difficulties	___	___		
Emotional/Psychological Problems	___	___		
Bowel or Bladder Problems	___	___		
Severe/Frequent Headaches	___	___		
Vision/Hearing Difficulties	___	___		
Dizziness or Faintness	___	___		
Are you Pregnant	___	___		
Do you Smoke	___	___		
Alcohol Consumption	___	___		
	Daily	Weekly		



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 Northern Arizona Rehabilitation & Fitness 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.

Patient/Parent/Guardian Signature: _____ Date: _____

I acknowledge that I have seen the "Notice of Privacy Practices". I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: _____ Date: _____