



W231 S7680 Big Bend Dr  
 Big Bend, WI 53103  
 Phone: (262) 662-9760  
 Fax: (262) 662-9761

**PATIENT INFORMATION** **EMAIL ADDRESS:** \_\_\_\_\_

First Name:	Last Name:	Middle Initial:	Date: / /
Address:		City:	State: Zip:
Birth date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By <input type="checkbox"/> Dr.: <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend			
<input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:			

**WORK INFORMATION**

Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed	

**CARE PROVIDER INFORMATION**

Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

**INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**

Primary Insurance Name:	
Subscriber's Name (If different):	Birth date: / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date: / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	

**AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**

Insurance Name: <input type="checkbox"/> Auto :	<input type="checkbox"/> Labor & Industries:
Adjuster/Claim Manager:	Phone: Ext.:
Address:	City: State: Zip:
Claim #:	Accident Date: / / Cause:

**ATTORNEY INFORMATION**

Name:	Law Firm:	Phone: ( ) -
Address	City	State: Zip:

**IN CASE OF EMERGENCY**

Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Hammer Rehab & Fitness Center. I understand that I am financially responsible for any balance. I also authorize Hammer Rehab & Fitness Center to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE

DATE

# PAST MEDICAL HISTORY FORM

Patient Name \_\_\_\_\_

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION					
	YES	NO		YES	NO
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS					
	YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			

What types of exercise do you perform? : \_\_\_\_\_

What things cause stress in your life? : \_\_\_\_\_

Are you taking any seizure medication?  YES  NO If yes list name: \_\_\_\_\_

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?  
 YES  NO If yes list name: \_\_\_\_\_

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

List all surgeries in the past two years (Including dates): \_\_\_\_\_

Are you pregnant?  YES  NO What week?: \_\_\_\_\_

Have you had any injuries related to work?  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had any Auto Accidents  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had Physical Therapy or Massage Therapy before?  YES  NO Where: \_\_\_\_\_

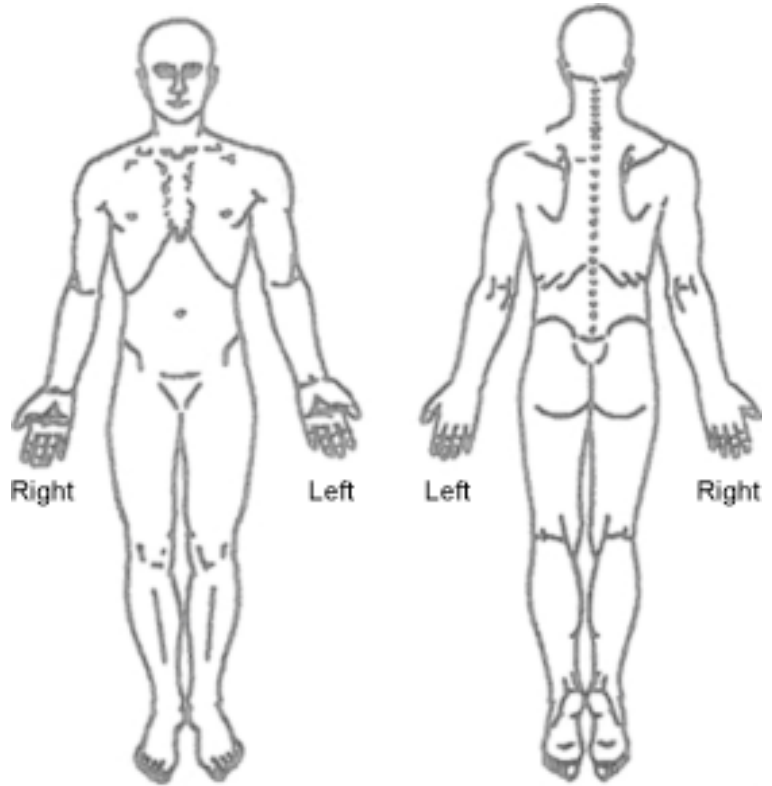
Signature of Patient, Parent, Guardian, Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

- |   |                                      |                                |
|---|--------------------------------------|--------------------------------|
| <b>Ache</b><br>MMMM<br>MM                       | <b>Burning</b><br>---<br>--          | <b>Numbness</b><br>OOOO<br>OOO |
| <b>Pins &amp; Needles</b><br>□□□□□□□□<br>□□□□□□ | <b>Stabbing</b><br>/////////<br>//// | <b>Other</b><br>XXXXX<br>XXX   |



**Chief Complaint and Visual Analog Scale**

My Chief Complaint is: \_\_\_\_\_

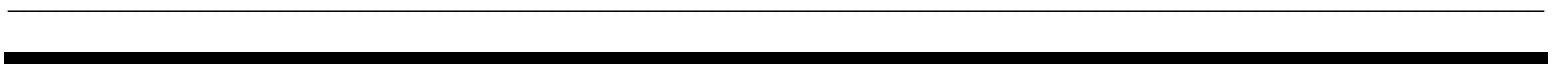
Date First Symptom of Your Problem Occurred on: \_\_\_\_\_

2<sup>nd</sup> Complaint: \_\_\_\_\_

3<sup>rd</sup> Complaint: \_\_\_\_\_

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it gets
Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it gets
Please circle on the scale below to indicate your <u>WORST</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it gets

Additional Comments: \_\_\_\_\_





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**CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

Your protected health information will be used by this practice, known as Hammer Rehab & Fitness Center or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

**SIGNATURE SECTION**

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

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Name of Patient (Print Clearly)

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Signature of Patient

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Date

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Signature of Patient Representative

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Relationship of Patient Representative to Patient