Patient Name (First, MI, Last)	Date of Birth	Sex ☐M ☐F	Home Phone
Present Address City State Zip			Cell Phone
Date of Occurrence	E-mail Address	Social Security #	
Cause of Injury: ☐Auto Accident ☐ N/A ☐Workers' Comp	Doctor's Diagnosis	Referring Physician	
Primary Insurance	Subscriber # or ID #	Group or Plan #	
Secondary Insurance	Subscriber # or ID #	Group or Plan #	
(For Office Use Only) Verify Insurance Coverage			Initials

IF INJURED IN AN AUTO ACCIDENT PLEASE FILL OUT BOX BELOW

Auto Insurance being billed	Claim #	Adjuster or Agent Name	Phone #

IF INJURED IN WORK RELATED ACCIDENT PLEASE FILL OUT BOX BELOW

Employer or Insurance Company	Claim #	Adjuster or Employer Contact	Phone #

Authorization to Collect for Services Rendered

I hereby authorize Agape Therapy to furnish any information to any and all insurance carriers concerning me or my dependents. I also hereby assign to Agape Therapy all payments for services rendered to me or my dependents. I understand that I am solely responsible for any charges incurred that are not subsequently covered by my insurance.

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement I have received a copy of Agape Therapy's Notice of Privacy Practices.

Cancellation/No Show Policy:

There will be a $25 fee charged to any patient who doesn't keep an appointment as scheduled, or fails to notify us of a cancellation **prior to 5:00 p.m**. the previous business day.

Informed Consent

The patient may be under the control of his/her physician and consents to any treatment or procedures rendered the patient by this agency under the general and specific instructions of the physician. It is further understood that the agency is hereby relieved of any and all liability occurring from the performance of the physician's instructions. I request and authorize the staff to provide me with physical, occupational and or speech therapy and to perform any procedures now ordered or such additional procedures as may be authorized by my physician.

Are you receiving care from any Home Health services at this time? Yes _____ No_____

X Signature : _____ Date: _____

*If you signed as the **patient's representative**, please print your name, describe your relationship to the patient below.*

_____ _____

Name *Relationship to Patient*

AGAPE therapy REHAB RESTORE RECLAIM

the ACCESS plan
MEDICAL HISTORY FORM

Level 1
Level 2

Name	Sex	Today's Date	Birthdate	Emergency Contact and Phone #
Address	Email		Cell Phone	Employer: Duty: ___ PT ___ FT
Doctor Name Doctor Location	**Is this condition**: *1. Fall related?* yes no *2. Automobile related?* yes no *3. Work related?* yes no			**Have you had therapy anywhere this year?** yes no # of visits _____ **Are you getting in home care?** yes no
How do you learn best? seeing doing hearing			**Do you have difficulty:** hearing seeing speaking reading	
How did you hear about us? (circle) Doctor order TV Commercials Drive by Been here before Friend Other:				

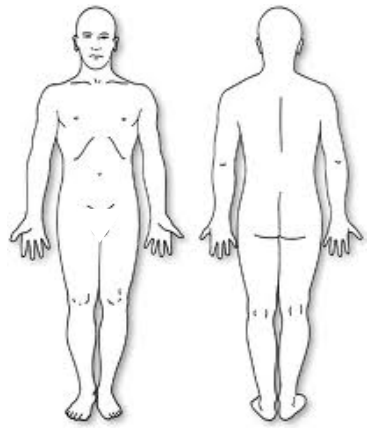
-IN REGARD TO CURRENT CONDITION/ISSUE-

Be specific, what is your chief complaint, include symptoms?

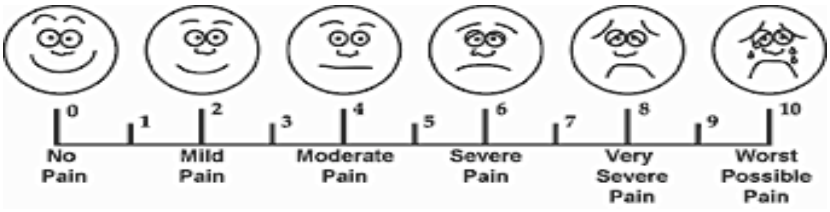
Is this the first episode? no yes If no, when was the first episode?

Symptoms since (date): **Symptoms (circle):** intermittent constant | getting better worse no change

Where is your pain? Mark on the person where your pain is and note type of pain.



Pain Intensity: ____/10 current _____/10 at best _____/10 at worst



Pain gets better with:
bending sitting turning rising standing walking lying AM PM as day progresses when still moving other

Pain gets worse with:
bending sitting turning rising standing walking lying AM PM as day progresses when still moving other

What is limited because of chief complaint: sleep self care housework reaching pushing pulling lifting carrying sitting standing bending squatting walking community access other

Sleep position: back belly right side left side recliner restless other:

Any other notes:

It's your choice where you get therapy, thank you for choosing Agape!

-MEDICAL HISTORY-

(Please fully answer these questions; you would be surprised how this helps us to help you!)

Please list and describe any injuries/falls/accidents/traumatic experiences, including past.

1.
2.
3.

Please list ALL…			
	Describe	When	Did it help?
Surgeries			
Injection(s)			
Any Imaging:	Xray CT Scan MRI Other:		
Other practitioners: (list)			
Other			

Medical History/Diagnosis(s)				
	When	Describe	Is it managed?	Any lasting effects?
Cancer				
Diabetes I or II				
Cardiovascular				
Respiratory				
Vascular(Strokes, etc)				
Infectious disease(s)				
Hepatitis				
Arthritis				
Other:				

List any allergies: **Do you carry**?: inhaler epi pen other:

Family History in regard to current condition:

What *Relationship to patient*

List current Medications/Vitamins/Supplements:

Name *Purpose*

Health Considerations: *Smoking*: currently _____ history _____

Alcohol: currently _____ history _____ rarely ___ a few times/month ____ everyday ____

Pregnancy: currently _____, # of weeks along _____ # of total pregnancies _____

Are you having issues with (circle):

changes in bowel/bladder	unexplained weight loss	symptoms with cough/sneeze
difficulty swallowing	ringing ears	dizziness
nauseous	always hot or cold	mood changes
skin changes	extreme fatigue	passing out
foggy mind	other :	

To the best of my ability, I have included all pertinent medical information. I also give consent to receive therapy by qualified staff and/or participate in fitness or physical activity opportunities.

Patient/Guardian Signature: _____ Date: _____

-Agape thanks you for your completeness; we promise it will help give you great care!