SWLA Sports & Rehab Center
Patient Information

Date:________________________

First Name:_______________________________________ **MI:**___________ **Last Name:**____________________________________

Social Security Number: __________________________________ **Gender:** Male Female **Date of Birth:** ______________________

Marital Status: Single Married Widow Divorced **Status:** Student Employed Retired

Mailing Address:____ **Physical Address:**____

City:____ **State:**_____________________ **Zip:**_________________

Home Phone #:____ **Cell Phone #:**____

Was condition related to: ( ) **Employment** ( ) **Auto Accident** ( ) **Other**___________________________________

Date condition / Accident began:____________________________

Referring Physician:____ **Next Appointment:**______________________________

Family Physician:____

Employer:____ **Employer Phone #:**_____________________________________

PRIMARY INSURED'S INFORMATION

(This is the person, if different from the patient, whose name appears on your insurance card. If more than one name appears on the insurance card, the primary or first person named on the card.)

Name:____ **Address:**____

City:____ **State:**_______________ **Zip:**_______________________________________

Relationship to Patient:______________________ **SS #:**___________________________ **Date of Birth:**_______________________
(month/day/year)

Please provide contact information where someone can be reached in case of EMERGENCY while patient is receiving therapy

Name:____________________________________ **Relationship:**________________ **Phone Number:** _________________________

Is this an emergency contact? Y N

Is this person permitted to discuss your medical information? Y N

ARE YOU CURRENTLY RECEIVING HOME HEATLH SERVICES? ( ) YES ( ) NO
(Home Health Service includes any medical care or assistance by a nurse or doctor or therapist in your home.)

Have you received physical therapy for this condition before? ( ) Yes ( ) No

Please tell us how you heard about SWLA Sports & Rehab Center ?

Radio Ad___ **Newspaper Ad** ___ **Physician** ___ **Friend** ___ **Other** _______________________________________

Medical History   Name: ______________________   Date: ________________

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low Blood Pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? ◯ Yes ◯ No
Two or more falls in the last year? ◯ Yes ◯ No
Patient is at risk for falls? ◯ Yes ◯ No

Surgical History

Body Region: ____________________ Surgery Type: ______________________ Date: _____________, ______, _________

Body Region: ____________________ Surgery Type: ______________________ Date: _____________, ______, _________

Body Region: ____________________ Surgery Type: ______________________ Date: _____________, ______, _________

Current Medications

Drug: _____________ Dosage: ______ Frequency: __________ Route: __________ Reason Taking: ____________________

Drug: _____________ Dosage: ______ Frequency: __________ Route: __________ Reason Taking: ____________________

Drug: _____________ Dosage: ______ Frequency: __________ Route: __________ Reason Taking: ____________________

☐ **Currently not taking any medications**
☐ **Are you pregnant**
☐ **Do you have a pacemaker**

SOUTHWEST LOUISIANA SPORTS & REHAB CENTER

Functional Activities

Patient's Name: ____ Date: _______________

Functional Activity	No Difficulty	Minimal Difficulty	Moderate Difficulty	Maximal Difficulty
1. Sitting	______	______	______	______
2. Standing	______	______	______	______
3. Walking in the Home	______	______	______	______
4. Walking in the Neighborhood	______	______	______	______
5. Using Stairs	______	______	______	______
6. Driving	______	______	______	______
7. Getting in/out of Car	______	______	______	______
8. Shopping	______	______	______	______
9. Rolling in Bed	______	______	______	______
10. Bathing	______	______	______	______
11. Grooming	______	______	______	______
12. Getting Dressed	______	______	______	______
13. Preparing food/Cooking	______	______	______	______
14. Reaching	______	______	______	______
15. Lifting/Carrying _____#	______	______	______	______

Southwest Louisiana Sports and Rehabilitation Center, LLC

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one, or all, of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:__________________________________ Relationship:_____________________

Name:__________________________________ Relationship:_____________________

Name:__________________________________ Relationship:_____________________

Name:__________________________________ Relationship:_____________________

____
Patient Name

____
Patient Signature

____
Date