Rehab Oasis
Improving lives with hands that care

Patient History Sheet

Date: ____ / ____ / 20____
dd / mm

Patient Information

Name:	**Height:**	**Weight:**
Address:		
Phone: Home:	**Mobile:**	**Work:**
Date of Birth:	**Email:**	

I consent to receiving text messages, emails, and/or phone communications from Rehab Oasis and its authorized representatives and I understand I have the right to opt out of Rehab Oasis's authorized communications as well as information sharing to third parties concerning my information for home exercise and scheduling services.

How did you hear about Rehab Oasis? ☐ Self ☐ Friend/Family ☐ Doctor ☐ Employer ☐ Event ☐ Google ☐ Website ☐ Instagram ☐ Facebook ☐ Other

Name/Title of person who referred you:	**Phone:**
Primary Care Physician:	**Phone:**
Emergency Contact:	**Relationship:** **Phone:**

MEDICAL HISTORY **Do you have/had any of the following medical illnesses/concerns? Please tick (✓) inside the box**

	Heart Problems		**Pregnant**		**Smoke**		**Seizures**
	High Blood Pressure		**Diabetes**		**Asthma**		**HIV/AIDS**
	Pacemaker		**Cancer**		**Osteoporosis**		**Stroke**

List all current medications, and include amount/frequency (i.e. Cataflam, 50 mg, every 6 hours):

Do you have any allergies? *If yes, please list*

Please describe your chief physical complaint and (i.e. back pain):

How/When it happened (i.e. lifted a box at work, two weeks ago):

Have you had previous therapy for this problem/injury? ☐ Yes ☐ No If yes, was it helpful? ☐ Yes ☐ No

What other surgeries/injuries have you had in the last five years?

Work Information Injury related to a work accident? ☐ Yes ☐ No *If yes, please complete this section.*

Employer name: Phone:

Address:

Position:

Present work status (circle):
Full-time/Regular Part-time/Regular Full-time/Modified Part-time/Modified Not working Unemployed Retired

Auto Accident Information Injury related to an auto accident? ☐Yes ☐ No *If yes, please complete this section*

Auto insurance company:

Attorney name: Phone:

Health insurance company: Name of primary insured:

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Informed Consent for Care and Treatment

Physical Therapy: The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation and intervention by use of rehabilitative procedures, mobilization, manual techniques, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to me before they are performed.

Informed Consent for Treatment: The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand that the physical therapist provides a wide range of services and I will receive information at the initial visit concerning the treatment and options available for my condition. I will notify my practitioner if I am pregnant, become pregnant, or am trying to get pregnant. I understand I am encouraged to communicate with a physician the potential benefits and risks of treatment relevant to my pregnancy.

Potential Benefits: Benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the recourses available to me.

Potential Risks: I may experience an increase in my current level of pain or discomfort, or aggravation of my existing injury during physical therapy. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

No Warranty: I understand that my physical therapist cannot make any promises or guarantees regarding a cure for or improvements in my condition. I understand that my physical therapist will share with me his/her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Cancellation Policy: In the event that I need to cancel a scheduled appointment, I agree to provide the courtesy of 24-hours notice so that Rehab Oasis can offer my appointment to patients waiting on the standby list. If two scheduled appointments are missed without reasonable cause, Rehab Oasis reserves the right to notify the referring physician's office and/or case manager/insurance company.

I have read the above information and I consent to physical therapy evaluation and treatment. My signature below acknowledges that I have read, understood and will abide by the conditions and policies noted on this consent form.

_____	_____	_____
Signature of Patient or Representative	Name of Patient or Representative	Date

_____

Witness