Hand-N-Hand Therapy, LLC 4850B 31st Street S Arlington, VA 22206

Date: _____

Name:		(married	d / single	/ divorced /	widow / other)			
	Visit reminder notification: Email /text / answer machine							
Street	email:							
City	State	Zip						
MEDICARE #	Оссир	oation						
Home phone	_Cell		Work					
In case of emergency, contact			Phone_					
Referred by	How did y	ou hear about	:us?					
Insurance Information Do you I have been advised that I am research schedule may be 115% above To Is Medicare your primary? YES I understand this office is a certified particle deductible and the co-payment of 20% for secondary insurance plans so there may	sponsible for payment ricare's allowable rate S NO P cipating Medicare pro- or services rendered. I	P art A or vider, but I am HNH does NO	Part B responsik T particip	(please ple for full pa pate with Med	circle) yment of my			
Is Medicare your secondary? Do you need Pre-Certification?	YES YES	NO NO	(som	ne insurers	ll bill for you) s like GEHA)			
Plan name								
Insurance address								
Insurer's Phone	Group#							
Policy holder/Birthdate	Relationship to patient							
Is this workers compensation? Ye WC Claim #:								
	Patient Author	-	iaiiie					
I,	necessary information sheet is correct, and I n, for this or any relate y be revoked by me, in f a repeat nature. I als Finally, I know it my r	charges or confor the promp further authorized claim. I per n writing, at an so know there	ppays for so t process ze the rele mit a copy by time. I us is a copy or decline	services rending of my clase of any report of this authoristand the of the HNH perfections of the HNH perfections.	dered. If it is nim. hecessary orization to here may be orivacy policy hilosophy			
Signature of patient or parent/guar	rdian			Date				

Patient N	lame:							Page 2
Leisure Act	tivities:							
Your currer	nt treatment (Goals:						
At the prese	ent time wou	ld you say yo	our health is: (circle)	: Excellen	t Very G	ood Fa	air	Poor
What techn	iques do yοι	use for rela	kation:					
	al doctor (MI path	D)	ose care you're und Psychiatrist/Psych Physical Therapist Chiropractor	ologist				
			uring the <i>past three</i> of care. What provi					
Allergi Anemi Anxiet Arthrit Asthm Autoin Bronc Cancel Cardia Cardia Chemi	es ia iy tis namune Dis chitis r c Conditic c Pacema cal Depen	Circular Current Deprest Diabete Dizzy S sorder Fibrom Fractur ons ker dency eries or oth	es pells DEmphysema yalgia	Hepatiti High Che HIV/AID Incontin Kidney F Metal I MRSA Multiple der issues es mpairment which you I	s olesterol S ence Problems mplants e Sclerosis	ORheu OSeizu OSmol OSpee OStrok OTube OVisio SOLyi Cular Discoporosis	mato res king ch Pr es rculo n Pro me ease	oblems oblems sis blems
DATE			y/Hospitalization	DATE		on for Sur	ierv/H	ospitalization
			y				<u>, . , ,</u>	
			injuries for which		been treate	ed (includ	ling fr	actures,
Patient g Name:	ives perm	ission to c	liscuss medical		vith anoth one:	er perso	n: Ye	es / No

		your immediate family (parent	ts, brothers	, sisters)				e following?		
YES	NO	Diabetes			YES	NO	Cancer			
YES	NO	Heart Disease			YES	NO	Alcoholism			
YES	NO	High Blood Pressure			YES	NO	Depression			
YES	NO	Stroke			YES	NO	Kidney Dise	ase		
YES	NO	Inflammatory Arthritis (Rheum	natoid, Ankyl	osing)						
Which	of the fo	ollowing medications have you	ı taken in th	e last we	ek?					
			Physician	Prescribe	ed	Not P	rescribed by	Physician		
Aspirin			YES /	NO NO		YES / NO				
Tylenol			YES / NO			YES / NO				
Anti-infl	amatorie	es (Advil/Motrin/Ibuprofen, Etc.)				YES / NO				
		nedications	YES /	NO NO		YES / NO				
Vitamin	s/minera	al supplements	YES /	NO NO		YES / NO				
		Remedies	YES / NO			YES / NO				
		scribed by a physician								
	•	, , ,								
Please	list any F	PRESCRIPTION medication you	are currentl	y taking, I	NCLUDIN	IG pills,	injections, and	or skin patches.		
In the p	ast vear	I have fallentir	nes	Did fall r	esult in a	n iniurv?	YES /	NO		
How mu	uch caffe	einated coffee or caffeine contain	ning beverag	es do you	drink per	day? _				
How ma	any cigar	rettes do you smoke a day?	For ho	ow many y	/ears?		If quit, wh	nen?		
How ma	any days	per week do you drink alcohol?	·	_ How mu	ich per da	y?				
		your diet and water intake:								
		allergies:								
Have v	ou recer	ntly experienced?:								
•										
YES	NO	weight loss/gain	YES	NO		nuscle s				
YES	NO	nausea/vomiting	YES	NO		oruising				
YES	NO	excessive bleeding	YES	NO			e or work			
YES	NO	fatigue	YES	NO		Ity breat				
YES	NO	weakness	YES	NO			time cough			
YES	NO	fever/chills/sweats	YES	NO	arm/le	eg swelli	ng			
YES	NO	numbness or tingling	YES	NO	heart	racing ir	n your chest			
YES	NO	tremors	YES	NO		Ity swall				
YES	NO	spider/tick/animal bite	YES	NO		ourn/ind				
YES	NO	injury	YES	NO		pation/c				
YES	NO	periodontal /gum disease	YES	NO		in stools				

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Patient Name:

YES

YES

YES

YES

YES

NO

NO

NO

NO

NO

dry eyes

skin rash

problems sleeping

sexual difficulties

night sweats

Any architectural barriers or safety issues in your home we should know about? (stairs, steps, slopes, walkways, ...)

YES

YES

YES

YES

YES

NO

NO

NO

NO

NO

post menopause

problems urinating

blood in the urine

urinary incontinence/frequency

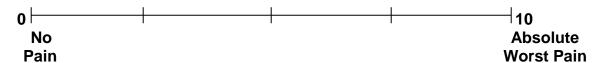
pregnant, or think you might be pregnant

RESERVED FOR FURTHER COMMENTS

Fatigue Visual Numeric Scale (Please circle your fatigue level in the past 2 weeks)

No fatigue 0______l___10 Exhaustion

Visual Pain Scale (Please mark your worst pain level in past 24 hours)



Please use the following body diagrams to indicate any pain (///), numbness (ooo), or tingling (xxx).

