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

**Date:** _____

Name: _____ ( married / single / divorced / widow / other )

Birthdate:_____ Visit reminder notification: Email /text / answer machine

Street_____ **email:**_____

City _____ State _____ Zip _____

MEDICARE # _____Occupation _____

Home phone _____Cell _____Work_____

In case of emergency, contact _____**Phone**_____

Referred by_____ How did you hear about us?_____

**Insurance Information-- Do you have Tricare? YES NO**

I have been advised that I am responsible for payment of services rendered and understand the HNH fee schedule may be 115% above Tricare's allowable rate.

**Is Medicare your primary? YES NO Part A or Part B** (please circle)

I understand this office is a certified participating Medicare provider, but I am responsible for full payment of my deductible and the co-payment of 20% for services rendered. HNH does **NOT participate** with Medicaid or secondary insurance plans so there may be a copay, especially with HMO and some Basic plans.

**Is Medicare your secondary? YES NO (**if yes, HNH will bill for you**)**
**Do you need Pre-Certification? YES NO (**some insurers like GEHA)

Plan name_____ID #_____

Insurance address_____

Insurer's Phone_____ Group#_____

Policy holder/Birthdate_____ Relationship to patient_____

Is this workers compensation? **Yes No** Carrier name:_____
WC Claim #:_____ Adjuster's name: _____

## Patient Authorization

I, _____understand that, although I might be covered under a medical insurance policy, I am primarily responsible for payment of any charges or copays for services rendered. If it is Workers Compensation, I will provide all necessary information for the prompt processing of my claim.
I certify the information provided on this sheet is correct, and I further authorize the release of any necessary information, including medical information, for this or any related claim. I permit a copy of this authorization to be used in place of the original and it may be revoked by me, in writing, at any time. I understand there may be a $75 fee for short notice cancellations of a repeat nature. I also know there is a copy of the HNH privacy policy for my review, both online and in person. Finally, I know it my right to accept or decline treatment philosophy and interventions made on my behalf by HNH staff, and will be referred elsewhere if preferred by me.

Signature of patient or parent/guardian _____ Date _____

Leisure Activities: _____

Your current treatment Goals:_____

At the present time would you say your health is: (circle): **Excellent** **Very Good** **Fair** **Poor**

What techniques do you use for relaxation: _____

_____

Please check any of the following whose care you're under:

| | | |
|---|---|---|
| ____Medical doctor (MD) | ____Psychiatrist/Psychologist | Other_____ |
| ____Osteopath | ____Physical Therapist | _____ |
| ____Dentist | ____Chiropractor | _____ |

If you have seen any of the above during the *past three months*, please describe for what reason (illness, medical condition, physical, etc.) and results of care. What provides you with relief? _____

_____

_____

**Have you EVER been diagnosed as having any of the following conditions?** *Check all that apply*

| | | | |
|---|---|---|---|
| ◯Allergies | ◯Circulation Problems | ◯Hepatitis | ◯Rheumatoid Arthritis |
| ◯Anemia | ◯Currently Pregnant | ◯High Cholesterol | ◯Seizures |
| ◯Anxiety | ◯Depression | ◯HIV/AIDS | ◯Smoking |
| ◯Arthritis | ◯Diabetes | ◯Incontinence | ◯Speech Problems |
| ◯Asthma | ◯Dizzy Spells | ◯Kidney Problems | ◯Strokes |
| ◯Autoimmune Disorder | ◯Emphysema | ◯ Metal Implants | ◯Tuberculosis |
| ◯ Bronchitis | ◯Fibromyalgia | ◯MRSA | ◯Vision Problems |
| ◯Cancer | ◯Fractures | ◯Multiple Sclerosis | ◯Lyme |
| ◯Cardiac Conditions | ◯Gallbladder issues | ◯Muscular Disease | |
| ◯Cardiac Pacemaker | ◯Headaches | ◯Osteoporosis | |
| ◯Chemical Dependency | ◯Hearing Impairment | ◯Parkinson's | |

**Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:**

| DATE | Reason for Surgery/Hospitalization | DATE | Reason for Surgery/Hospitalization |
|---|---|---|---|
| | | | |
| | | | |

**Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate <u>date of injury</u>:**

Patient gives permission to discuss medical condition with another person: **Yes / No**

Name:_____ Phone:_____

**Patient Name:** _____ 

**Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the 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 Disease |
| YES | NO | Inflammatory Arthritis (Rheumatoid, Ankylosing) | | | |

**Which of the following medications have you taken in the last week?**

| | **Physician Prescribed** | **Not Prescribed by Physician** |
|---|---|---|
| Aspirin | YES / NO | YES / NO |
| Tylenol | YES / NO | YES / NO |
| Anti-inflamatories (Advil/Motrin/Ibuprofen, Etc.) | YES / NO | YES / NO |
| Stomach ulcer medications | YES / NO | YES / NO |
| Vitamins/mineral supplements | YES / NO | YES / NO |
| Herbals/Other Remedies | YES / NO | YES / NO |

Others NOT prescribed by a physician _____

_____

Please list any PRESCRIPTION medication you are currently taking, INCLUDING pills, injections, and/or skin patches.

| | | |
|---|---|---|
| | | |
| | | |

In the past year I have fallen _____times. Did fall result in an injury? **YES / NO**
How much caffeinated coffee or caffeine containing beverages do you drink per day? _____
How many cigarettes do you smoke a day? _____ For how many years? _____ If quit, when? _____
How many days per week do you drink alcohol? _____ How much per day? _____
Please describe your diet and water intake: _____
Specify known *allergies*:_____

**Have you recently experienced?:**

| | | | | | |
|---|---|---|---|---|---|
| YES | NO | weight loss/gain | YES | NO | joint/muscle swelling |
| YES | NO | nausea/vomiting | YES | NO | easy bruising |
| YES | NO | excessive bleeding | YES | NO | stress at home or work |
| YES | NO | fatigue | YES | NO | difficulty breathing |
| YES | NO | weakness | YES | NO | daytime/nighttime cough |
| YES | NO | fever/chills/sweats | YES | NO | arm/leg swelling |
| YES | NO | numbness or tingling | YES | NO | heart racing in your chest |
| YES | NO | tremors | YES | NO | difficulty swallowing |
| YES | NO | spider/tick/animal bite | YES | NO | heartburn/indigestion |
| YES | NO | injury | YES | NO | constipation/diarrhea |
| YES | NO | periodontal /gum disease | YES | NO | blood in stools |
| YES | NO | dry eyes | YES | NO | post menopause |
| YES | NO | skin rash | YES | NO | problems urinating |
| YES | NO | problems sleeping | YES | NO | urinary incontinence/frequency |
| YES | NO | sexual difficulties | YES | NO | blood in the urine |
| YES | NO | night sweats | YES | NO | pregnant, or think you might be pregnant |

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

## RESERVED FOR FURTHER COMMENTS

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

**No fatigue 0**_____**I**_____**10 Exhaustion**

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

**0** — **No Pain** — **10 Absolute Worst Pain**

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