NEW PATIENT W/C INTAKE

PATIENT NAME: _____M/F_____

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____

HM. PHONE_____CELL PH._____WK. PH._____

BIRTHDATE: _____

CLAIM# OR SSN #: _____

D.O.I. _____

ATTORNEY REPRESENTATION: _____

HAVE YOU TREATED ELSEWHERE? Y/N

IF YES, WHERE? _____

EMPLOYER'S NAME: _____

STREET ADDRESS: _____

EMPLOYER'S PHONE: _____

SUPERVISOR'S NAME: _____

PRIMARY CARE PHYSICIAN _____

ADDRESS: _____

PHONE#: _____

DATE AND TIME OF IHP: _____LOCATION:_____

DO YOU HAVE HEALTH INSURANCE? Y / N

WHO IS THE CARRIER? (bring insurance card to appointment)_____

_____

DO YOU HAVE CAR INSURANCE? Y / N

WHO IS THE CARRIER? _____

DO YOU HAVE MED-PAY? Y / N (bring insurance card)

NAME OF PRIMARY CARE PHYSICIAN:_____PHONE#_____

PLEASE DESCRIBE HOW THE ACCIDENT HAPPENED: _____

_____

_____

_____

_____

WHAT STREET WERE YOU TRAVELING ON? _____

$ DAMAGE ESTIMATE TO CAR? _____

IF AN **MVA**, WERE YOU THE (circle)? driver / front seat passenger / back seat passenger/other

CAR: YEAR _____MAKE _____MODEL _____

OTHER VEHICLE: YEAR_____MAKE _____MODEL _____

WAS THE CAR: (circle) STOPPED SLOWING DOWN MOVING

WERE YOU: (circle) REAR-ENDED / HIT HEAD-ON / SIDESWIPED / TURNED IN FRONT OF YOU

DID THE AIR BAGS DEPLOY? Y / N

WERE YOU JOLTED? (circle) SIDEWAYS BACKWARD FORWARD

DID YOU HAVE IMMEDIATE PAIN? Y / N

WHERE? _____

DID YOU HIT ANY PART OF YOUR BODY? _____

WHO RESPONDED TO THE SCENE? (circle) POLICE / AMUBLANCE / FIRE DEPARTMENT

DID YOU GO THE ER / URGENT CARE / PRIMARY CARE PHYSICIAN? Y / N

WHERE? _____

TRANSPORTED BY AMBULANCE? Y / N X-RAYS TAKEN? Y / N OF WHAT?

_____

WHAT SYMPTOMS DID YOU COMPLAIN OF IN ER /UC / PCP? _____

_____

WERE YOU GIVEN ANY MEDICATIONS WHILE IN THE ER? Y / N WHAT?

_____

WERE YOU PRESCRIBED MEDICATIONS TO TAKE AT HOME? Y / N WHAT?

_____

_____

DID YOU MISS WORK? Y/N HOW MANY DAYS/ LIST DATES: _____

_____

WHAT INJURIES OR SYMPTOMS ARE COMPLAINING OF NOW? _____

_____

IS THE PAIN (circle) MILD – MODERATE - SEVERE - RADIATING - NUMBNESS TINGLING - WORSE AT NIGHT - CONSTANT - INTERMITTENT

OTHER: _____

DO YOUR INJURIES CAUSE DIFFICULTY: (circle) DRIVING - ENTERING AND EXITING A CAR - LOOKING OVER YOUR SHOULDER - REMOVING WET CLOTHES FROM THE WASHING MACHINE - LIFTING – BENDING - LIFTING AND PLACING WET CLOTHES IN THE DRYER - COOKING - STAIRS - PULLING TOPS OVER YOUR HEAD - YARD WORK - SITTING - WALKING - VACUUMING - WASHING WINDOWS SNOW SHOVELING – SLEEPING - RESTLESSNESS - GET OUT OF BED - CARING FOR CHILDREN/GRANDCHILDREN/RAISING ARMS TO WASH AND COMB HAIR

OTHER:

_____

_____

PAST MEDICAL HISTORY (INCLUDE PAST SURGICAL HISTORY):

_____

G.I. BLEEDING Y / N STOMACH ULCERS Y / N KIDNEY PROBLEMS Y / N

HIGH BLOOD PRESSURE Y / N DIABETES Y / N PREGNANT Y / N CARDIAC

PROBLEM Y / N DRUG ADDICTION Y / N HEPATITIS Y / N HIV/AIDS Y / N

PACEMAKER Y / N FOREIGN METAL Y / N

ALLERGIES: _____

CURRENT MEDICATIONS: _____

_____

PREVIOUS INJURIES: _____

_____

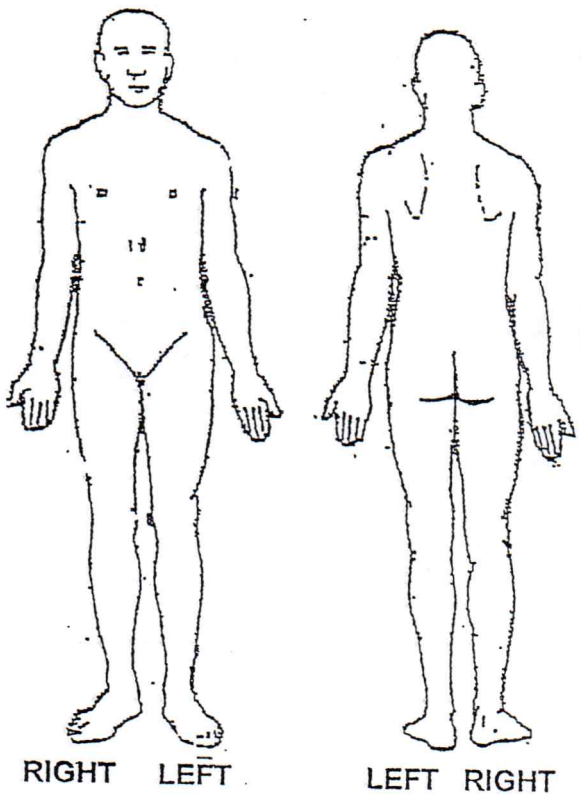
Today's Date_____

INITIAL VISIT FORM

Name_____

PAIN DRAWING

Carefully shade or mark the areas where you feel any pain on the drawing below



This form will allow Cleveland Therapy to obtain your medical records relating to this injury, from the hospital emergency room, urgent care center of family physician.

AUTHORITY TO RELEASE MEDICAL AND/OR HOSPITAL RECORDS

Patient Name_____ Date of Birth_____

Date of Admission on or about_____

You are hereby authorized and directed to permit this therapy center to examine, photostat, and copy any and all reports and records pertaining to my treatment rendered at your hospital, urgent care center, and/or physician's office on or around the above date.

Please furnish the undersigned with a copy of the records indicated below:

_____ Emergency Room Records

_____ Urgent Care Records

_____ Physician Progress Visit

_____ X-ray, CT Scan, MRI Reports

_____ Consultation

_____ Other _____

Cleveland Therapy's physicians would like these medical records faxed to the below circled location.

1. Cleveland Therapy - Brainard
   Brainard Place Medical Building
   29001 Cedar Road, Suite 309
   Lyndhurst, Ohio 44124-4041
   Fax 216-721-4441
   Phone 216-721-4955

2. Cleveland Therapy - West
   West Valley Medical Building
   20455 Lorain Road, Suite 102
   Fairview Park, Ohio 44126-3529
   Fax 440-734-4184
   Phone 440-734-4084

3. Cleveland Therapy – Parma
   York Executive Building II
   6325 York Road, Suite 203
   Parma Heights, Ohio 44130-3030
   Fax 440-842-1796
   Phone 440-842-1229

The patient has the right to revoke this request within 7 business days, by contacting Cleveland Therapy either by phone or letter. This should be directed to where the medical records are stored.

20455 Lorain Road, Suite 102
Fairview Park, Ohio 44126
440-734-4084

A COPY OF THIS RELEASE AND AUTHORIZATION SHALL SERVE AS THE ORIGINAL

Signature_____ Date_____

This form allows Cleveland Therapy to forward your records to your insurance carrier, local medical doctor, and/or attorney.

NAME_____

SSN#_____

DATE OF INJURY_____

I hereby authorize and permit this therapy center to examine, or Photostat all reports, itemized patient bills and records including Emergency Room and hospital reports, police reports, x-ray reports, and other reports pertaining to my treatment rendered in regard to the above date of injury. The records can then be forwarded to my insurance carrier, local medical doctor, and or attorney at the completion of my treatment.

SIGNATURE_____ DATE_____

MEDICAL RECORDS FASCIMILE TRANSMISSION AUTHORIZATION

I, _____, understand that you will be transmitting my medical records electronically, and authorize you to do so. If they are received by another party in error, I absolve this therapy center of any and all liability relating to such submission of said records.

A COPY OF THIS RELEASE AND AUTHORIZATION SHALL SERVE AS THE ORIGINAL

SIGNATURE_____DATE_____

This allows Cleveland Therapy to be paid for your medical treatment by your attorney.

ASSIGNMENT FOR PAYMENT OF PROVIDER'S FEE

Date of Accident: _____

Name: _____

I do hereby assign to this therapy center the amount due for services and goods rendered to me, from my recovery resulting from a claim or law suit arising from my accident.

I hereby direct my attorney to honor this assignment as a lien against any funds that might be due me as a result of such claim or law suit, and my attorney is hereby authorized and directed to issue payment directly, without any further approval by me.

This assignment is irrevocable without the approval of this therapy center.

The execution does not make the fee due to the therapy center contingent upon my securing a recovery in any loss or claim that I may have against any party or insurance company, nor does this assignment preclude this therapy center from demanding payment at any time after service is rendered.

Signed: _____

Date: _____

/assign1