

BRAZOSPORT REHABILITATION & WELLNESS, L.L.C.
321 Garland Drive, Lake Jackson, TX 77566 Phone: (979) 297-3365 Fax: (979) 297-3541

PATIENT PERSONAL DATA

Patient Name: _____ DOB: _____

Address: _____ MD: _____

Phone 1: _____ Phone 2: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Diagnosis: (list all): _____

Reason for evaluation: _____

Medication: (attach list if necessary):

Medication	Dose/Frequency	Reason for taking
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Past Medical History (choose all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gout | <input type="checkbox"/> Swallowing Problems |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Headaches | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Trauma (TBI) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Impairments | <input type="checkbox"/> Stroke/CVA |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Visual Problems |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hernias | <input type="checkbox"/> Joint/Muscle Problems |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Foot/Ankle |
| <input type="checkbox"/> Coordination Loss | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Knee |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Back |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Otosclerosis | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Polio | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Elbow |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Skin Disease/Cancer | <input type="checkbox"/> Wrist/Hand |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

PAIN SCALE:

We will ask you to grade your pain on a scale of 0 to 10. We will also be asking you about your pain levels before during and after therapy services.

0 = No pain 10 = You must go to the emergency room

Circle Where you rank your pain RIGHT NOW:

0 1 2 3 4 5 6 7 8 9 10

What is the BEST your pain has been over the past two weeks:

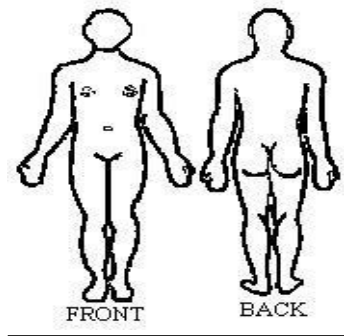
0 1 2 3 4 5 6 7 8 9 10

What is the WORST your pain has been over the past two weeks:

0 1 2 3 4 5 6 7 8 9 10

MARK YOUR PAIN ON THE BODY DIAGRAM:

Severe Pain: XXXXXX
Moderate Pain://///////
Tingling: ++++++++
Numbness: OOOOOOO
Shooting Pain: -----



_____(Sign) I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of BRAZOSPORT REHABILITATION & WELLNESS, L.L.C (HIPAA) and BRAZOSPORT REHABILITATION & WELLNESS, L.L.C policies and procedures regarding the use and disclosure of any of my protect health information created, received and maintained by BRW. (version 12/2019)

_____(Sign) I hereby give consent for myself or my child (if a minor) to receive medical treatment at BRW.

_____(Sign) I hereby authorize my insurance carrier, plan, organization, hospital, employer, surgeon, physician, or anesthetist to release any information concerning my care that is requested by BRAZOSPORT REHABILITATION & WELLNESS, L.L.C.

_____(Sign) I have read the BRW financial agreement and understand my financial responsibility for treatment rendered at BRAZOSPORT REHABILITATION & WELLNESS, L.L.C. (version 12/2019)

_____(Sign) I have received/reviewed the attendance policies for Brazosport Rehabilitation and Wellness, LLC. (version 12/2019)

