Patient Demographic Form

Patient's full name: _____

Date of Birth: _____ Sex: _____ Social Security Number: _____

Email: _____ Cell Phone: _____

Home Phone: _____ Work phone: _____ ext: _____

Preferred method of communication: email ____, cell phone _____, home phone _____, work phone _____

If cell phone (check if applicable): send mobile text notifications ____, send voice notifications _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Ethnicity: Hispanic or Latino _____, Not Hispanic or Latino _____, Patient declines to specify _____

Preferred Language _____ Race _____

Next of Kin Contact/Emergency contact Name: _____

Relation to patient: _____ Phone: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Patient's mother's maiden name: _____ Driver's License state & #: _____

Primary Insurance: _____ Secondary Insurance: _____

Primary Care Physician: _____

Preferred Pharmacy:_____

I give my consent for MJF Rehabilitation, PA to retrieve my prescription history: _____ Yes _____ No

MJF Rehabilitation, PA
240 Wesley Drive
Kerrville, TX 78028
830-315-2106

Physical Medicine and Rehabilitation

Patient History Form

Please fill in the following information:

Patient Name: _____ Date: _____

Height: _____ Weight _____ Influenza Vaccine__yes___no Pneumonia Vaccine ___yes___no

1. Past Medical History – Please list all illnesses and injuries

_____

_____

_____

_____

_____

2. Past surgical History – Please list all surgeries/operations

_____

_____

_____

3. Medication Allergies – Please list all allergies to medications and side effect

Allergy Side Effect

_____

_____

4. Current Medications – Please list all current medications and dosages

Medication Dose Reason for taking medication

_____

_____

_____

_____

_____

_____

_____

_____

5. Social History

Tobacco use ____Never ____Current – Quantity_____ _____Quit

Alcohol use ____Never ____Current – Quantity_____ _____Quit

Occupation _____

6. Family History – Please list any illnesses of your blood relatives

_____

_____

_____

MJF Rehabilitation, PA
240 Wesley Drive
Kerrville, TX 78028
830-315-2106

Health Care Consent & Authorization Form

Consent and Authorization for Treatment

I consent and authorize MJF Rehabilitation, PA ("MJF") to provide the necessary examinations, diagnostic and therapeutic tests, procedures, and provide general care and treatment as determined necessary and/or ordered by those healthcare professionals involved in my care.

Financial Responsibility Agreement and Assignment of Benefits

I understand I am financially responsible for all charges and bills associated with my care and treatment, except to the extent that all or part of these charges or bills are paid or covered by health insurance, a government healthcare program (such as Medicare or Medicaid), a financial assistance program, or another party responsible for their payment (all of which are referred to as "Third Party Payers"). I authorize MJF to submit bills or claims and related information concerning my health status, care, treatment, and payments made for my care and treatment to any applicable Third Party Payer and its business associates. I also authorize such Third Party Payers to make payments directly to MJF in response to these bills or claims.

I understand that billing of insurance is a service only and not a guarantee of payment. If a Third Party Payer requires pre-certification for services, I realize it may be my responsibility to get the necessary approvals. I understand that in the event a Third Party Payer determines a service to be "not covered" or denies payment for any reason, I will be responsible for the complete charge. Payment will be due upon receipt of a statement from MJF.

Authorization to Release Information

I consent and authorize MJF to furnish my Health Information contained in my medical records to Third Party Payers concerning my illness and treatments in order to process my insurance claim. I agree to allow a photocopy of my signature to be used to process my insurance claim. A scanned copy of this assignment is to be considered as valid as the original.

I consent and authorize MJF to release and exchange my Health Information with other healthcare professionals and organizations involved in my care and with business associates that MJF have contracted for the same reasons and to those I have listed below.

Name _____ DOB _____

_____ _____

Acknowledgement of the Notice of Privacy Practice

I have reviewed the Notice of Privacy Practices of MJF Rehabilitation, PA and I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

I understand the information in this form and agree to the conditions set forth above.

Printed Name of Patient/Responsible Party _____

Signature _____ Date _____

MJF Rehabilitation, PA
240 Wesley Drive
Kerrville, TX 78028
830-315-2106

Appointment Cancellation Policy Agreement:

MJF Rehabilitation, PA is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at 830-315-2106 by 2:00 p.m. on the business day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday. If prior notification is not given, you will be charged $45.00 for the missed appointment.

Please sign below to consent to these terms:

_____ _____

Patient Signature (Patient's Parent/Guardian if under 18) Date

MJF Rehabilitation, PA
240 Wesley Drive
Kerrville, TX 78028
830-315-2106

Please check the appropriate boxes for symptoms present or absent in the last 6 months

Patient Name: _____					Date: _____				
				Review of Systems					
			Yes	**No**				**Yes**	**No**
	1. Constitutional					**9. Endocrine**			
Weight change					Diabetes				
Fever/chills					Thyroid disease				
Sweats									
Fatigue						**10. Musculoskeletal**			
					Aching muscles/joints				
	2. Eyes				Swelling of joints				
Double vision					Back pain				
Decreased vision					Painful feet				
					Muscle cramping/spasms				
	3. Ears, Nose, Throat				Weakness				
Sore Throat									
Dizziness						**11. Neurological**			
Loss of Hearing					Numbness				
					Seizures				
	4. Cardiovascular				Dizziness				
Chest pain					Headache				
Palpitations					Coordination problems				
Uncontrolled blood pressure					Speech difficulties				
Leg pain after exertion					Swallowing problems				
					Walking difficulties				
	5. Respiratory				Tremor				
Cough									
Shortness of breath						**12. Psychiatric**			
					Depression				
	6. Gastrointestinal				Mood Swings				
Reflux					Anxiety				
Hepatitis					Hallucinations				
Diarrhea					Memory problems				
Constipation					Sleep pattern changes				
					Alcohol/drug problems				
	7. Urinary System								
Incontinence						**13. Hematological**			
Retention					Swollen glands				
Hesitancy					Excessive bruising/bleeding				
	8. Skin								
Rashes									
Wounds									

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.