HULSEY THERAPY SERVICES
Rehab & Sports Medicine

PATIENT INFORMATION

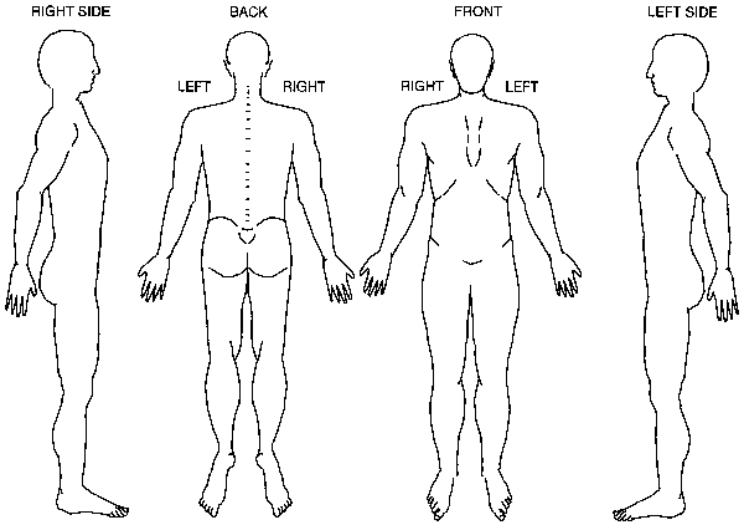
PATIENT

First Name : _____ MI ____ Last : _____ DOB : _____AGE : _____

SS # : _____ Phone Number : _____ Emergency Contact/Phone : _____

PAIN

Please mark the areas on the drawing below where you feel discomfort or pain



RATE YOUR OVER-ALL DISCOMFORT ON THIS 0 –TO- 10 SCALE

1	2	3	4	5	6	7	8	9	10

ONSET

Date of Injury –or- Onset of Symptoms : _____ Have you had surgery : NO YES : Date _____

How Were You Injured : _____ Is this Workers Comp : NO YES

Chief Complaint :_____

Prior Treatment for this condition : NO YES _____ Where : _____ When : _____

MEDICAL HISTORY

Circle if you have any of the following

Diabetes	Blood Pressure Problems	Pace Maker/Defibrillator	Currently Pregnant : No Yes
Kidney Problems	Heart Problems	Mental Illness	Joint Replacements
Epilepsy	Arthritis	Stroke	Blood clots
Lung Condition	Cancer :_____	Osteoporosis	_____

Surgeries : _____

Allergies : NO YES _____

Other Medical Issues or Treatments :_____

Current Medications : See List Provided _____

MEDICARE ONLY

This area is for patient who have Medicare as their insurance carrier - Disregard if this does not apply to you.

Medicare may not be primary in all cases. Medicare requires healthcare providers to ask the following question to help distinguish if Medicare is truly primary
Do you have coverage under any of the following : **NO** **YES** *(if YES , please circle the ones which apply to you)*

Workers Comp *Black Lung* *VA* *Auto Accident* *Employer Group Health Plan* *End Stage Renal Benefits* *Disability*

Provider Billing for Medical and Other Health Services (*Based on form approved OMB No. 0938-0013*)

I authorized Hulsey Therapy Services PC (HTS) , (Medicare provider number 67-6522) , to provide outpatient rehab services to me. I also agree to allow HTS to bill CMS on my behalf, and receive payments for such services directly to HTS.

_____

Signature of Patient Date