266 S. Harvard Blvd. #330
Los Angeles, CA 90004
Tel (323) 939-0840
Fax (323) 939-0850

Welcome to Genesis Rehab Therapy. The following information will help your rehabilitation experience be more effective and rewarding. Please read the statement below and sign where indicated. Thank you.

1. I agree to keep all of the appointments I schedule.

2. If I cannot come to an appointment, I will provide as much notice as possible. I understand that if I do not provide 24-hour notice I may be charged $40 for a missed, broken, or canceled appointment. (Insurance companies do not cover this fee).

3. I understand that if 3 or more appointments are missed or re-scheduled without notice, consecutively or not, I may be discharged from rehabilitation services. (Genesis will notify your NCM/ADJ/MD).

4. I will notify the front office, and my therapist, at least 24-48 hours prior to a scheduled doctor's appointment, so they may send a progress report to the doctor.

5. I understand that my home program, exercises and activities are an important part of my therapy process. I will support my progress from therapy by following recommendations daily. I understand that if I have concerns or questions about my home program, I can contact my therapist.

6. I understand my insurance plan may have limitations to the amount of services I can receive and a time frame in which services must be scheduled.

7. I am responsible for all co-pays and insurance percentages, which are due prior to my treatment.

Patient Print Name	Patient Signature	Date

Genesis
REHAB THERAPY

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New Patient Form

Patient Name: _____ Date of Birth: _____

Cellphone #: _____ Home Telephone #: _____

Email Address: _____

Home Address: _____

Primary physician: _____ Orthopedic Doctor: _____

Insurance: _____ Insured Name: _____

Describe your main complaint: _____

Have you had a previous surgery to this area? No Yes If yes, date of surgery: _____

How the injury occurred: _____

What makes your pain/symptoms worse? _____

What makes your pain/symptoms better? _____

What is your job? Describe your task at your workplace: _____

_____

Does your condition interfere with your sleep? If so, how many times do you wake and how long does it take to go back to sleep? _____

Please rate your current pain level between 0 to 10 (0= no pain, 10=highest possible pain) _____

Are your symptoms: better worse no different in the am?

Are your symptoms: better worse no different in the pm?

List your frequent activities outside of the workplace: _____

Have you had an x-ray, lab test, MRI, bone scan, CT-scan for this injury? _____
If yes, where was it taken? Which body part is it? _____

_____	_____	_____
Patient Print Name	Patient Signature	Date

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Patient Name: _____

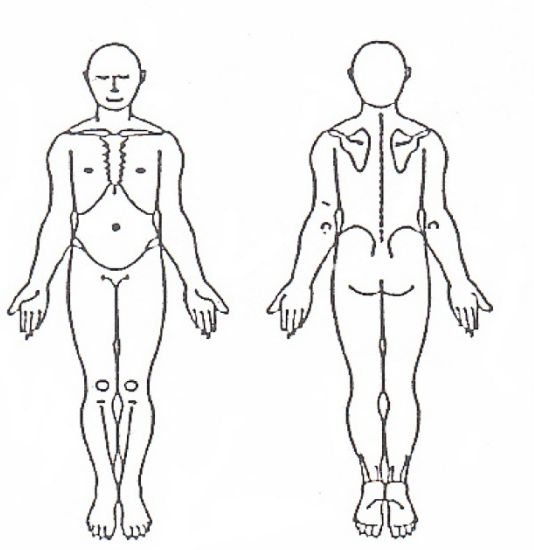
PLEASE CIRCLE YES OR NO

Yes No Diabetes
Yes No High Blood Pressure
Yes No Heart Disease
Yes No Cancer or Tumors
Yes No Lung Disease
Yes No Kidney or Liver Problems
Yes No Arthritis or Joint Problems
Yes No Seizures or Nervous Disorders
Yes No Stroke
Yes No Allergies
Yes No Dermatitis (skin problems)
Yes No Eye Problems (glaucoma/cataracts)
Yes No Hernia
Yes No Unusual or frequent headaches
Yes No If female, are you pregnant?
Yes No Any joints replaced or pacemakers?
Yes No Have you taken long-term medication?
Yes No Have you ever taken steroids long term?
Yes No Are you currently taking medication?
Yes No Have you ever had surgery not related to this injury? (PLEASE LIST ON BACK OF SHEET)
Yes No Have you been in a cast, splint, or sling?
Yes No Do you use shoe lifts, corset or braces?
Yes No Are you currently being treated by another PT, Doctor, Chiropractor, Masseuse, or Podiatrist?

Are there any health problems not mentioned above?
_____

Please list all current medications:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please mark current areas of pain/problems/symptoms:



Patient signature:_____