Patient Name:
Patient File #:

The
Rose Center
for
Rehabilitation, Hope & Wellness

I. Authorization for Treatment

I authorize THE ROSE CENTER licensed/certified staff to provide treatment as per my plan of care.

Initial _____

II. Contact information

- ❑ I give permission to be called regarding my appointments.
- ❑ You may leave a message at my home # _____
- ❑ You may leave a message at my work #_____
- ❑ You may leave a message on my cell #_____
- ❑ You may email my information if I ask you to. Email:

Initial _____

III. Authorization to pay THE ROSE CENTER

I hereby authorize my insurance benefits to be paid directly to THE ROSE CENTER. I understand that I am financially responsible for co-pays, deductibles, and non-covered services.

I authorize THE ROSE CENTER to release any information needed to process my insurance claim.

Initial _____

IV. HOME HEALTH / TREATMENT BY ANOTHER FACILITY AT THE SAME TIME

Out-patient physical therapy will be denied by Medicare and most insurance companies if:

- **Physical Therapy is performed at two clinics on the same day**
- **Home health services are currently in progress —**

CIRCLE: YES / NO

HOME HEATH CAN BE - Nursing, PT, Speech, OT, bathing assistance

If you have an open Home Healthcare case, you will be asked to sign an Advanced Beneficiary Notice (ABN).

Initial _____

V. Patient Information Consent

I have read and fully understand The Rose Center's NOTICE OF INFORMATION PRACTICES (available in lobby). I understand The Rose Center may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that The Rose Center will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in The Rose Center's NOTICE OF INFORMATION PRACTICES. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initial _____

VI. Appointment Policy

Please allow one hour for your appointment. Please arrive 5-10 minutes prior to your appointment. New clients arrive 20 minutes prior to your Evaluation. If you need to cancel or reschedule your appointment, please give a 24-hour notice. If you do miss your appointment and you did not call, we can charge you $35.00 for the hour that you missed.

Initial _____

VII. Reason for visit:

- **Work Related: Yes / No**
- **MVA Related Yes / No**
- **Have had any visits of PT, OT, ST or chiropractic visits: yes / no**
- **How many visits this year? _____**

Date: _____

Signature of Client: _____

Guardian - Print Name: _____

Signature of Guardian: _____

Patient Name:
Patient File #:

The
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for

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Authorization for Release of Medical Information

Release of records FROM The Rose Center (please check the options below)

I hereby authorize **THE ROSE CENTER FOR REHABILITATION, HOPE AND WELLNESS** at 3278 Bechelli Lane, Redding, CA, 96002 to disclose information from my records:

Name	Any records	Appointment Info Only
Family Member: _____	☐	☐
Family Member: _____	☐	☐
Caregiver: _____	☐	☐
Physician: _____	☐	☐
Transportation Company: _____	☐	☐
Vendor for Equipment: _____	☐	☐
Other: _____	☐	☐

Release of records TO The Rose Center (please check any that apply)

I hereby authorize the following companies and doctors to release my records of X-Rays, C-T scans, MRI, Notes and Reports to **THE ROSE CENTER FOR REHABILITATION, HOPE AND WELLNESS** at 3278 Bechelli Lane, Redding, CA, 96002:

- ❑ MD Imaging
- ❑ Advanced Imaging
- ❑ Shasta Regional Medical Center
- ❑ Mercy Medical Center
- ❑ Other: _____
- ❑ Other: _____

Consent Signature

I understand I may revoke this consent at any time, except where information has already been released.

Signature	Date	Witness	Date
Signature	Date	Witness	Date
Signature	Date	Witness	Date

Patient Name:
Patient File #:

The Rose Center

for

Rehabilitation, Hope & Wellness

PAST MEDICAL HISTORY

Date Of Birth:_____ Date:_____

1. Please check if you have ever had:

☐ Arthritis/gout	☐ Low Blood Sugar	☐ Nausea/vomiting	☐ Difficulty walking
☐ Broken bone/fracture	☐ Head Injury	☐ Sudden weight loss	☐ Joint pain/swelling
☐ Osteoporosis	☐ Metal Implant	☐ Bowel problems	☐ Hearing problems
☐ Blood Disorders	☐ Cancer	☐ Urinary problems	☐ Vision problems
☐ Seizure/Epilepsy	☐ Skin Diseases	☐ Kidney problems	☐ Latex Allergy
☐ Heart Problems	☐ Pacemaker	☐ Repeated Infections	☐ Other:_____
☐ High Blood Pressure	☐ Lung Problems	☐ Neurological (Stroke, Parkinson, etc)	
☐ Migraines	☐ Thyroid Problems	☐ Developmental or growth problems	
☐ Cough	☐ Infectious Diseases	☐ Circulation/vascular problems	
☐ Coordination problems	☐ Pain at night	☐ Diabetes	
☐ Weakness in arms or legs	☐ Difficulty sleeping	☐ Ulcer/stomach problems	
☐ Loss of balance/falls	☐ Loss of appetite	☐ Mental Illness	

Please explain any box checked: _____

2. Within the past 6 months, have you had any of the following symptoms? (Check all that apply)

☐ Chest Pain	☐ Flu/Fever/chills/sweats	☐ Sores that haven't healed
☐ Heart Palpitations	☐ Headache	☐ Wart/Mole (changed in size, shape, color)
☐ Hoarseness	☐ Currently pregnant	☐ Other:_____
☐ Shortness of breath	☐ Unexplained weight loss	
☐ Dizziness or blackouts	☐ Smoke _____(how often?)	

3. Have you ever had surgery? (circle one) Yes No If yes, please describe and include dates: _____
_____
4. Please provide a list of your medications or any dietary supplements (ie calcium). ☐ See List ☐ None
5. List any allergies, including medications. ☐ See List ☐ Wrote on back
6. Diagnostic Studies:

	Date	By Whom?		Date	By Whom?
X-rays	_____	_____	Discogram	_____	_____
MRI	_____	_____	Arthrogram	_____	_____
CT Scan	_____	_____	Injections	_____	_____
Myelogram	_____	_____	VNG/ENG	_____	_____
EMG	_____	_____	Hearing	_____	_____

7. Do you exercise regularly? Yes No If yes, what type and how often? _____
8. Do you have discomfort, shortness of breath, or pain with exercise? Yes No
9. What is your occupation? Or retired from? _____

Patient Name:
Patient File #:

The
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for
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PATIENT HISTORY QUESTIONNAIRE

Date:_____ Age:_____ Occupation:_____

1. Where is your pain/problem: _____
2. Date of onset of the pain / surgery / injury (circle one):_____
3. Briefly describe how / why your pain started:_____

_____

_____

4. The pain is currently getting…: (circle one) Better Worse Same Activity Dependent
5. Pain Level: _____ Scale 0 = no pain --------- moderate pain ---------- 10 = severe pain – going to E.R.
6. Stress Level: _____ Scale 0 = no stress --------- moderate stress -------- 10 = severe stress
7. Action or positions that make the pain worse:

TMJ

- ☐ Chewing
- ☐ Swallowing
- ☐ Clenching
- ☐ Grinding
- ☐ Wakes me at night
- ☐ Other:_____
- ☐ Talking
- ☐ Closing the mouth
- ☐ Opening the mouth
- ☐ Lying on my side R/L
- ☐ Wearing my splint

Habits

- ☐ Biting my nails
- ☐ Chew gum/hard candy
- ☐ Chew Ice cubes
- ☐ Chew my cheek
- ☐ Chew items
- ☐ Other:_____

Do you have:

- ☐ A splint
- ☐ Braces
- ☐ A retainer
- ☐ Dentures / Partials
- ☐ Headaches assoc. with jaw pain

Neck / Upper back / Spine

- ☐ Looking down
- ☐ Looking up
- ☐ Sitting _____ min.
- ☐ Standing _____min.
- ☐ Exercise during / after
- ☐ Other:_____
- ☐ Coughing
- ☐ Sneezing
- ☐ Walking
- ☐ Lying down
- ☐ Wakes me at night
- ☐ Using a computer
- ☐ Reaching up / using arms
- ☐ Talking on the phone

8. Actions or positions that make you better: ☐ Splint therapy – wearing the splint – when?_____

_____

_____

9. Is your pain : ☐ better in the morning ☐ better at the end of the day ☐ activity dependent
☐ worse in the morning ☐ worse at the end of the day
10. Additional comments that might be helpful in your treatment:_____

Headaches: how often? _____

_____

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Patient Name:
Patient File #:

HEALTH INFORMATION

11. Diagnostic Studies:	Yes	No	Date
X-rays	☐	☐	_____
MRI	☐	☐	_____
CT Scan	☐	☐	_____
Myelogram	☐	☐	_____
EMG	☐	☐	_____
Discogram	☐	☐	_____
Arthrogram	☐	☐	_____
Injections	☐	☐	_____

12. Have you been hospitalized for this problem? (circle one): Yes (Date:_____) No

If yes, why:_____

13. What other healthcare providers have you seen for this condition? _____

TODAY

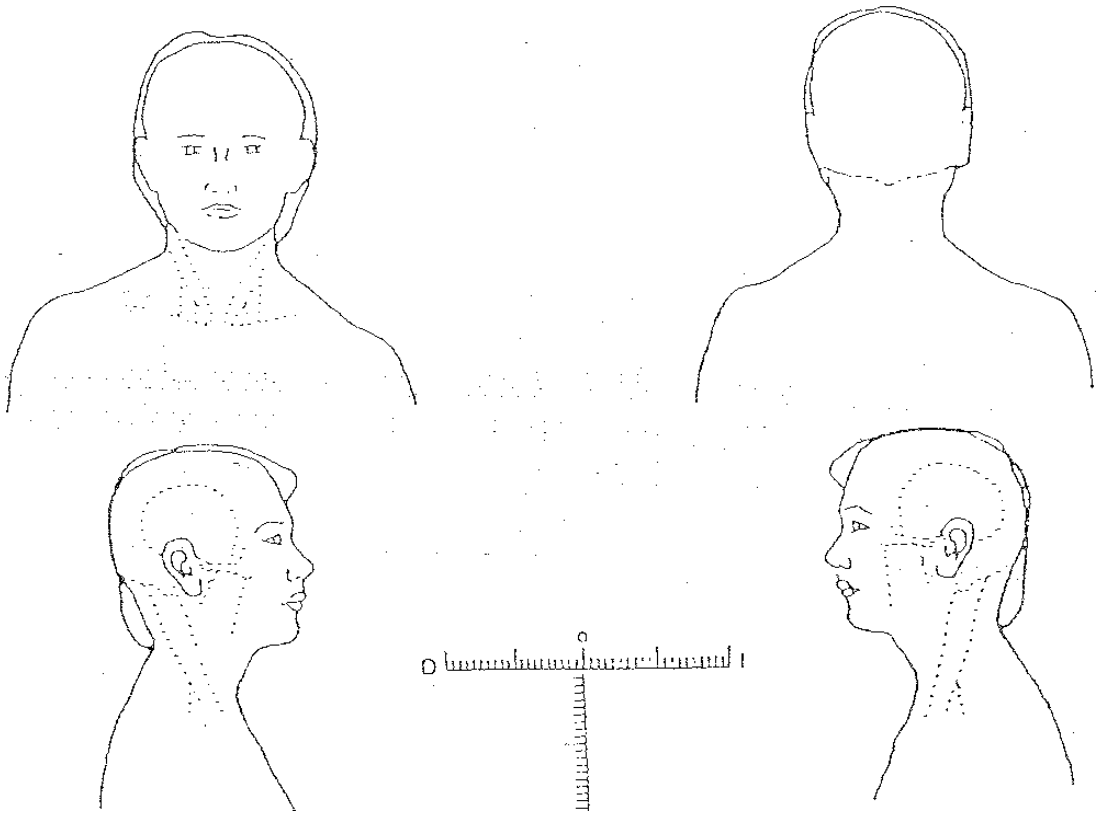
14. Where is your pain today? _____

_____

15. Pain level:_____ Scale 0=no pain-----moderate pain---10=severe pain - going to E.R.

16. Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
Also mark the areas where the pain spreads.

Aching	Numbness	Pins and Needles	Burning	Stabbing	"Sore"
AAAAA	>>>>>	00000	XXXXX	/////	✓✓✓✓✓



Reviewed by:
_____