ΣS_3 FITNESS REHAB
Personal Injury New Patient Questionnaire

Patient Information

Please Print **Date: ____/_____/_____**

Name_____ **SS#**_____-_____-_____

Address_____**City**_____ **State**_____ **Zip**_____

❑**Male** ❑**Female** ❑**Married** ❑**Single** ❑**Widowed** ❑**Divorced** ❑**Separated**

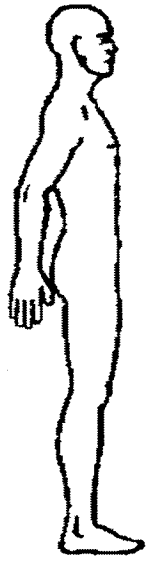
Birthdate_____ **Home Phone**_____ **Cell**_____

Work Phone_____ **E-mail Address**_____

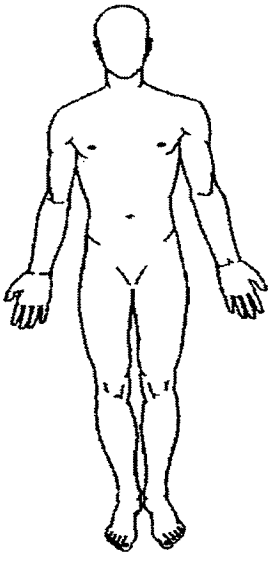
Employer_____ **Occupation**_____ **#years**_____

Emergency Contact_____ **Phone** _____ **Relation**_____

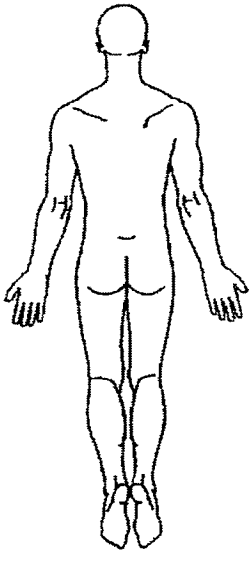
Please circle your area(s) of pain or discomfort using the figures below.



RIGHT



FRONT



BACK

LEFT

INSURANCE INFORMATION

Today's Date: _____

FINANCIAL	YOUR **AUTO INSURANCE** CARRIER	Primary **Claim** Information
NAME		
ADDRESS		
CITY/ST/ZIP		
POLICY #		
INSURED NAME		
OTHER FINANCIAL	OTHER **AUTO INSURANCE** CARRIER	Secondary **Claim** Information
NAME		
ADDRESS		
CITY/ST/ZIP		
POLICY #		
INSURED NAME		

WILL YOU HAVE LEGAL REPRESENTATION/ ATTORNEY ? Y__ N___

ATTORNEY INFORMATION	
NAME	
ADDRESS	
CITY/ST/ZIP	
PHONE #	

I hereby authorize the staff to perform services deemed as necessary by the physician to diagnose and treat my condition(S). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of information as is needed to process my claims. I understand I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment lieu of the original. This shall remain in effect until revoked by me in writing.

_____ _____

Signature Date

Health History - *Please circle all that apply*

HEART DISEASE	HYPERTENSION	HYPOTENSION	SEIZURES	STROKE
DIABETES	CANCER	ASTHMA	LUNG DISEASE	KIDNEY DISEASE
THYROID DISEASE	HEPATITIS	HIV	ARTHRITIS	ANEMIA
TUBERCULOSIS	GLAUCOMA	DEPRESSION	ANXIETY	MIGRAINE HEADACHES

LIST ANY OTHER CONDITION: _____

Previous Surgeries and Dates? _____

_____

How much do you smoke per day?_____ **Drink per week?** _____

WOMEN ONLY

Women - How many children?_____**Pregnant?**_____**Date of last Menstrual Cycle**_____

Nursing?_____**Taking Birth Control?**_____

List ALL Medications you are currently taking _____

_____

Any other health concerns/problems that you would like to disclose:

_____

_____

_____

***All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize- this office to release any information pertaining to my treatment to third party payers or other health care providers.**

Patient Signature_____ **Date**_____

HIPAA PATIENT AUTHORIZATION FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so. This authorization for release of information covers the period of healthcare from _____, 20__ to _____ ,20__ .

By signing this form, you authorize our use and disclosure to third parties, including but not limited to our billing and scheduling software, and our Clinic's franchisor, ES3 FITNESS REHAB, Inc., of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Authorization but later change your mind, you have the right to revoke this Authorization by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Authorization.

The patient understands and agrees that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this Authorization. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

All my medical records and protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes. The Clinic will not receive any payment from a third party for marketing purposes in connection with the use or disclosure of your PHI.

The Clinic or its business affiliates may use your PHI to contact you with appointment reminders and educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Authorization in writing at any time and all future disclosures that require the patient's prior written authorization will then cease. See the Notice of Privacy Practices for additional details.

The Clinic may not condition your treatment or payment on whether you sign this Authorization.

Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

The Authorization was signed by: _____
Printed Name - Patient or Representative

_____ _____
Signature Date

Relationship to Patient
(if other than patient) _____

_____
Witness: Printed Name - Clinic Representative

_____ _____
Signature Date.

For Internal Use:

O Patient Refused to Sign O Patient unable to sign for the following reason:

ΣS3 FITNESS REHAB

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and / or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to **ΣS3 FITNESS REHAB**, the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Illinois Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me / us for treatment rendered by the physician facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician / facility named above within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. I further instruct the provider to make all checks payable to **ΣS3 FITNESS REHAB**, and to send all checks to 231 E. 75th St Suite 2 Chicago, IL 60619

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable to **ΣS3 FITNESS REHAB**, and to send any and all checks to 231 E. 75th St Suite 2 Chicago, IL 60619

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician / facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician / facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician / facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my / our account or forwarded to my / our address upon request in writing to the physician / facility named above.

REJECTION IN WRITING: I hereby authorize the physician / clinic named above to establish a PIP or UM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider / clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per Illinois law (625 ILCS 5/7-203) of the Illinois Insurance Code, and further instruct my carrier to pay up to available limits directly to physician / clinic named above, and to send any and all checks or financial instruments to 231 E. 75th St Suite 2 Chicago, IL 60619

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he / she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician / facility immediately. I understand that failure to do so may jeopardize my case.

Signature of patient and / or responsible parties:

_____ Date _____

SPECIFIC AREAS OF COMPLAINT

1. Body Part: _____

   Date symptom first appeared: _____

   How often do you experience these symptoms?

   ☐ **Constant** 100% ☐ **Frequent** 75% ☐ **Occasional** 50% ☐ **Intermittent** 25% ☐ **Rare** 10%

   What makes this pain worse? _____

   What makes this pain better? _____

   Types of pain? ☐ **Sharp** ☐ **Dull** ☐ **Aching** ☐ **Burning** ☐ **Throbbing** ☐ **Numbness**

   ☐ **Other:**_____

   Please rate the intensity of your pain (0 being no pain, 10 being extreme)

   0 ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10

   Since the pain started has it stayed the: Same _____ Better _____ Worse _____

2. Body Part: _____

   Date symptom first appeared: _____

   How often do you experience these symptoms?

   ☐ **Constant** 100% ☐ **Frequent** 75% ☐ **Occasional** 50% ☐ **Intermittent** 25% ☐ **Rare** 10%

   What makes this pain worse? _____

   What makes this pain better? _____

   Types of pain? ☐ **Sharp** ☐ **Dull** ☐ **Aching** ☐ **Burning** ☐ **Throbbing** ☐ **Numbness**

   ☐ **Other:**_____

   Please rate the intensity of your pain (0 being no pain, 10 being extreme)

   0 ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10

   Since the pain started has it stayed the: Same _____ Better _____ Worse _____

3. Body Part: _____

   Date symptom first appeared: _____

   How often do you experience these symptoms?

   ☐ **Constant** 100% ☐ **Frequent** 75% ☐ **Occasional** 50% ☐ **Intermittent** 25% ☐ **Rare** 10%

   What makes this pain worse? _____

   What makes this pain better? _____

   Types of pain? ☐ **Sharp** ☐ **Dull** ☐ **Aching** ☐ **Burning** ☐ **Throbbing** ☐ **Numbness**

   ☐ **Other:**_____

   Please rate the intensity of your pain (0 being no pain, 10 being extreme)

   0 ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10

   Since the pain started has it stayed the: Same _____ Better _____ Worse _____

ΣS_3 FITNESS REHAB
ACCIDENT QUESTIONNAIRE

Name: _____

Date of Accident: _____ **Time:** _____ am pm

Vehicle you were in: Make _____ **Model** _____

OTHER vehicle: Make _____ **Model** _____

Were you the: Driver _____ **Pedestrian**_____ **Front Passenger** _____**Rear Passenger** _____

Other _____

Were you wearing your seat belt? Yes_____ **No** _____ **Did the airbag deploy? Yes**_____ **No** _____

Did any part of your body strike anything in the vehicle? Yes _____**No** _____ **If yes, please describe:**

_____

During impact, were you facing? Straight Ahead _____ **Down** _____ **Left** _____ **Right**_____

Other _____

Were you knocked unconscious? No _____ **Yes**_____ **If yes, how long?**_____

Where was your vehicle hit? Drivers side _____ **Passenger side** _____ **Front** _____ **Back**_____

Rear _____ **Rear Left** _____ **Rear Right** _____

What direction was your vehicle moving? Forward _____ **Reversing** _____ **Turning Left** _____

Turning Right_____ **Stopped** _____ **Other** _____

What was the approximate speed of your vehicle? _____**m.p.h. Unknown** _____

What was your vehicle Damage? Heavy _____ **Moderate** _____ **Light** _____ **Other** _____

What direction was the other vehicle moving? Forward _____ **Reversing** _____ **Turning Left** _____

Turning Right_____ **Stopped** _____ **Other** _____

What was the approximate speed of the other vehicle? _____**m.p.h. Unknown** _____

What was vehicle Damage to the other vehicle? Heavy _____ **Moderate** _____ **Light** _____

Other _____

Was your vehicle towed from the scene? Yes_____ **No** _____ **Police at the scene Yes**_____ **No** _____

Accident report taken? Yes_____ **No** _____ **EMS at the scene? Yes**_____ **No** _____

Did you go the hospital? Yes_____ **No** _____ **What hospital?** _____

Were X-rays taken? Yes _____ **No** _____ **Any other exams taken? Yes** _____ **No** _____

If yes, what exams? : _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature **Date**

Duties Performed Under Duress at Work and Home

Patient name_____ Date of Injury _____ Today's Date_____

☐ Initial ☐ Update

Please check all that apply to your WORK because of the accident

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the computer at work hurts
- ☐ Pushing at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ I cannot work because I am in pain
- ☐ _____
- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't use to
- ☐ I hide my poor work performance from my boss
- ☐ _____

Please check all that apply to your HOME/DOMESTIC because of the accident

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ I cannot take time off because I care for children
- ☐ I have _____children ages_____
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident

Signature _____ Date _____

Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School (1 of 2 pages)

Patient's name_____ Date of Injury_____ Today's date_____

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity because of the accident

☐ My exercise was affected by this crash	☐ I have gained_____ pounds since the accident
☐ I go to the gym & work out in pain	☐ I had to quit my _____ team after the accident
☐ I no longer go to the gym to work out	☐ I had to quit my _____team after the accident
☐ I run but in pain	☐ I had to quit my _____team after the accident
☐ I no longer run	☐ I had to quit my _____team after the accident
☐ I take walks & have pain while walking	☐ I don't enjoy the sport of _____anymore
☐ I no longer take walks	☐ I didn't enjoy the sport of _____for ____weeks
☐ I used to make income at sports	☐ I don't enjoy the sport of _____anymore
☐ I have lost sports income since crash	☐ I didn't enjoy the sport of _____for ____weeks
☐ I am an amateur athlete	☐ I don't enjoy the sport of _____anymore
☐ I am a professional athlete	☐ I didn't enjoy the sport of _____for ____weeks
☐ _____	☐ I don't enjoy the sport of _____anymore
☐ _____	☐ I didn't enjoy the sport of _____for ____weeks

Please check all that apply to your HOBBY Activities because of the accident

☐ My hobbies were affected by accident	☐Hobby #3_____
☐ Hobby #1_____	☐I can't do hobby #3 anymore
☐ I can't do hobby #1 anymore	☐I do hobby #3 but in pain
☐ I do hobby #1 but in pain	☐I have lost money from not doing #3
☐ I have lost money from not doing #1	☐I didn't do hobby #3 for _____ weeks
☐ I didn't do hobby #1 for _____ weeks	☐Hobby #4_____
☐ Hobby #2_____	☐I can't do hobby #4 anymore
☐ I can't do hobby #2 anymore	☐I do hobby #4 but in pain
☐ I do hobby #2 but in pain	☐I have lost money from not doing #4
☐ I have lost money from not doing #2	☐I didn't do hobby #4 for _____ weeks
☐ I didn't do hobby #2 for _____ weeks	☐_____

Please check all that apply to your TRAVEL Activities because of the accident

☐Business travel was affected by crash	☐ Travel Plan #1
☐Pleasure travel was affected by crash	☐ I did not go on travel plan #1
☐I hurt driving in my own car	☐ I went, but did not enjoy #1 as much
☐I am in too much pain to drive	☐ I went and the accident had no effect on #1
☐I hurt when a passenger in a car	☐ Travel Plan #2
☐I am in too much pain to sit in a car	☐ I did not go on travel plan #2
☐I have anxiety when I'm in a car	☐ I went, but did not enjoy #2 as much
☐I hurt when I'm on an airplane	☐ I went and the accident had no effect on #2
☐I am in too much pain too much pain to travel by plane	☐ I missed time with my family/friends b/c can't travel

Signature _____ Date _____

Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School (2 of 2 pages)

Patient's name_____ Date of Injury_____ Today's date_____

☐ Initial ☐ Update

Please check all the DAILY LIVING activities that cause you pain because of the accident

☐ Dressing
☐ Putting on pants
☐ Putting on shoes
☐ Tying my shoes
☐ Putting on shirt
☐ Drying my hair
☐ Combing my hair
☐ Washing my hair
☐ Taking a shower
☐ Taking a bath
☐ Leaning forward
☐ Laying in bed
☐ Sitting in my favorite chair
☐ Sleeping
☐ Going out with my friends
☐ Sitting at a restaurant
☐ Shopping
☐ Driving to/from work
☐ Sitting in Church
☐ Playing with my children
☐ Caring for my children
☐ Bending in a movie theatre
☐ Sitting in a movie theatre
☐ Exercise
☐ Eating
☐ Stooping
☐ Squatting down
☐ Kneeling
☐ Brushing my teeth

☐ Riding in a car
☐ Opening a jar
☐ Lifting a pan when cooking
☐ Closing the trunk on my car
☐ Opening the garage door
☐ Using my home computer
☐ Climbing stairs
☐ Sexual activity
☐ Turning my head to left or right
☐ Holding my head up all day
☐ Watching TV
☐ I have pain sitting & doing nothing
☐ Talking on the phone
☐ Reading
☐ Writing.

☐ Opening doors
☐ Drying with a towel after a bath or shower
☐ Life has become a chore just to do normal things
☐ It is depressing to live like this
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident

☐ School was affected by the accident
☐ I am a student at _____
☐ I am in the _____ year/grade
☐ I was ☐ full time ☐ part time
☐ I am now ☐ full time ☐ part time
☐ I had to take fewer classes b/c of crash
☐ I missed _____ days of school
☐ I had to drop out of school b/c of crash
☐ My grades are lower since the crash

☐ I have pain carrying my school books
☐ I hurt sitting in class more than _____ minutes
☐ My neck hurts when I look down to read
☐ I don't learn as quickly as before the crash
☐ I don't learn things as well as before the crash
☐ I have difficulty concentrating in class
☐ It takes much longer to study/do my homework
☐ _____
☐ _____

_____ _____
Signature of Patient Date