

Hand-N-Hand Therapy, LLC
4850B 31st Street S
Arlington, VA 22206

Date: _____

Name: _____ (married / single / divorced / widow / other)

Birthdate: _____ Visit reminder notification: Email /text / answer machine

Street _____

City _____ State _____ Zip _____

MEDICARE # _____ Occupation _____

Home phone _____ Cell _____ Work _____

In case of emergency, contact _____ Phone _____

Referred by _____ How did you hear about us? _____

Insurance Information-- Do you have Tricare? YES NO

I have been advised that I am responsible for payment of services rendered and understand the HNH fee schedule may be 115% above Tricare's allowable rate.

Is Medicare your primary? YES NO Part A or Part B (please circle)

I understand this office is a certified participating Medicare provider, but I am responsible for full payment of my deductible and the co-payment of 20% for services rendered. HNH does **NOT participate** with secondary insurance plans so there may be a copay with HMO and some Basic plans.

Is Medicare your secondary? YES NO (if yes, HNH will bill for you)
Do you need Pre-Certification? YES NO (some insurers like GEHA)

Plan name _____ ID # _____

Insurance address _____

Insurer's Phone _____ Group# _____

Policy holder/Birthdate _____ Relationship to patient _____

Is this workers compensation? **Yes No** Carrier name: _____

WC Claim #: _____ Adjuster's name: _____

Patient Authorization

I, _____ understand that, although I might be covered under a medical insurance policy, I am primarily responsible for payment of any charges or copays for services rendered. If it is Workers Compensation, I will provide all necessary information for the prompt processing of my claim. I certify the information provided on this sheet is correct, and I further authorize the release of any necessary information, including medical information, for this or any related claim. I permit a copy of this authorization to be used in place of the original and it may be revoked by me, in writing, at any time. I understand there may be a \$75 fee for short notice cancellations of a repeat nature. I also know there is a copy of the HNH privacy policy for my review, both online and in person. Finally, I know it my right to accept or decline treatment philosophy and interventions made on my behalf by HNH staff, and will be referred elsewhere if preferred by me.

Signature of patient or parent/guardian _____ Date _____

Patient Name: _____

Leisure Activities: _____

Your treatment current Goals: _____

At the present time would you say your health is: (circle): **Excellent** **Very Good** **Fair** **Poor**

What techniques do you use for relaxation: _____

Please check any of the following whose care you're under:

- | | | |
|--|--|-------------|
| <input type="checkbox"/> Medical doctor (MD) | <input type="checkbox"/> Psychiatrist/Psychologist | Other _____ |
| <input type="checkbox"/> Osteopath | <input type="checkbox"/> Physical Therapist | _____ |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Chiropractor | _____ |

If you have seen any of the above during the *past three months*, please describe for what reason (illness, medical condition, physical, etc.) and results of care. What provides you with relief? _____

Have you EVER been diagnosed as having any of the following conditions? Check all that apply

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> MRSA | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fractures | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Lyme |
| <input type="checkbox"/> Cardiac Conditions | <input type="checkbox"/> Gallbladder issues | <input type="checkbox"/> Muscular Disease | |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Parkinson's | |

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE	Reason for Surgery/Hospitalization	DATE	Reason for Surgery/Hospitalization

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Patient gives permission to discuss medical condition with another person: **Yes / No**

Name: _____ Phone: _____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES	NO	Diabetes	YES	NO	Cancer
YES	NO	Heart Disease	YES	NO	Alcoholism
YES	NO	High Blood Pressure	YES	NO	Depression
YES	NO	Stroke	YES	NO	Kidney Disease
YES	NO	Inflammatory Arthritis (Rheumatoid, Ankylosing)			

Which of the following medications have you taken in the last week?

	Physician Prescribed	Not Prescribed by Physician
Aspirin	YES / NO	YES / NO
Tylenol	YES / NO	YES / NO
Anti-inflammatories (Advil/Motrin/Ibuprofen, Etc.)	YES / NO	YES / NO
Stomach ulcer medications	YES / NO	YES / NO
Vitamins/mineral supplements	YES / NO	YES / NO
Herbals/Other Remedies	YES / NO	YES / NO
Others NOT prescribed by a physician _____		

Please list any PRESCRIPTION medication you are currently taking, INCLUDING pills, injections, and/or skin patches.

In the past year I have fallen _____ times. Did fall result in an injury? **YES / NO**

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many cigarettes do you smoke a day? _____ For how many years? _____ If quit, when? _____

How many days per week do you drink alcohol? _____ How much per day? _____

Please describe your diet and water intake: _____

Specify known *allergies*: _____

Have you recently experienced?:

YES	NO	weight loss/gain	YES	NO	joint/muscle swelling
YES	NO	nausea/vomiting	YES	NO	easy bruising
YES	NO	excessive bleeding	YES	NO	stress at home or work
YES	NO	fatigue	YES	NO	difficulty breathing
YES	NO	weakness	YES	NO	daytime/nighttime cough
YES	NO	fever/chills/sweats	YES	NO	arm/leg swelling
YES	NO	numbness or tingling	YES	NO	heart racing in your chest
YES	NO	tremors	YES	NO	difficulty swallowing
YES	NO	spider/tick/animal bite	YES	NO	heartburn/indigestion
YES	NO	injury	YES	NO	constipation/diarrhea
YES	NO	periodontal /gum disease	YES	NO	blood in stools
YES	NO	dry eyes	YES	NO	post menopause
YES	NO	skin rash	YES	NO	problems urinating
YES	NO	problems sleeping	YES	NO	urinary incontinence/frequency
YES	NO	sexual difficulties	YES	NO	blood in the urine
YES	NO	night sweats	YES	NO	pregnant, or think you might be pregnant

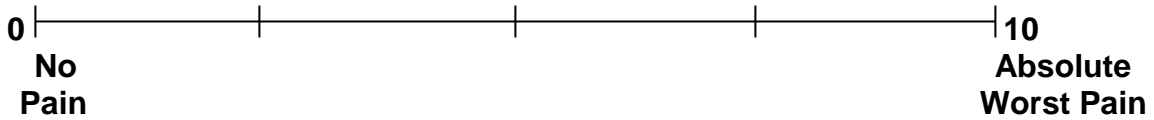
Any architectural barriers or safety issues in your home we should know about? (stairs, steps, slopes, walkways, ...)

RESERVED FOR FURTHER COMMENTS

Fatigue Visual Numeric Scale (Please circle your fatigue level in the past 2 weeks)

No fatigue 0 _____ | _____ 10 Exhaustion

Visual Pain Scale (Please mark your worst pain level in past 24 hours)



Please use the following body diagrams to indicate any pain (///), numbness (ooo), or tingling (xxx).

