754 N College Rd, Ste D,
Twin Falls, ID 83301
(208)734-5313

2634 Addison Ave E
Twin Falls, ID 83301
(208) 326-2000

1015 Main,
Buhl, Id 83316
(208) 543-8887

INFORMACION PERSONAL

Apellido _____ Primer Nombre _____ Inicial de Nombre Secundario _____

Domicilio _____ Ciudad _____ Estado ____ Código Postal _____

Telefono: Celular _____ Casa _____ Trabajo _____

Seguro Social # _____ Fecha de nacimiento_____ Sexo: ☐ Masculino ☐ Femenina

Correo electronico _____ Consentimiento para enviar un correo electronico?☐Si☐No

Edad ___ Estatura_____ Peso _____

Ocupacion y empleador _____ Esta trabajando al corriente?☐Si☐No

Esposo/Padre _____ Empleador de Esposo/Padre _____

Contacto de emergencia: Nombre _____ Numero de telefono _____ Relacion _____

Como supiste de nosotros?☐Medico ☐Amigo/Familia ☐Google ☐Paciente Anterior ☐Seguro ☐Redes Sociales ☐Otro

INFORMACION DE POLIZIA DE SEGURO *Por favor proveer todo la informacion de seguro, licencia de conducir, y otro informacion del pagador en el momento de check in (cuando llegas a la clinica).*

Lesion debido a:☐ Accidente automovilistico ☐Lesion del trabajo ☐ Accidente ☐ Deportes ☐Desconocido ☐ Otro

Pagara usando:☐ Seguro de salud personal ☐Seguro de auto ☐ Compensacion de trabajadores☐Auto pago

☐ Pago legal ☐ Otro _____

INFORMACION DE HERIDA/CONDICION

Que problema requiere terapia fisica? _____ Fecha de herida _____

Tuvo cirugia ☐Si ☐No Fecha de circugia _____ Tipo de cirugia _____

Medico que lo refirio _____ Medico que lo atiende regularmente _____

Restricciones de actividad por orden medico _____ Servicios actuales de salud en el hogar?☐ Si ☐ No

Tuvo terapia fisica, terapia de ocupacion, o terapia quiropractica este ano ☐ Si ☐ No

Cuales estudios que le han hecho para este problema: ☐X-ray ☐ MRI ☐CT/CAT ☐ EMG ☐Ninguno ☐Otro _____

Medicamentos actuales (o lista separada)	Cirugias Pasadas
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Uso de Oficina Solamente

Treatment Dx: *Medical Dx:* *DOI:* *DOS:*
Entered by: *Therapist:* *DOE:*

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INFORMACION DE HERIDA/CONDICION (CONTINUADA) *Por favor dibuja en el diagrama donde sientes sintomas:*

Por favor describa tus sintomas que dibujaste en el diagrama:

_____
_____
_____
_____
_____
_____
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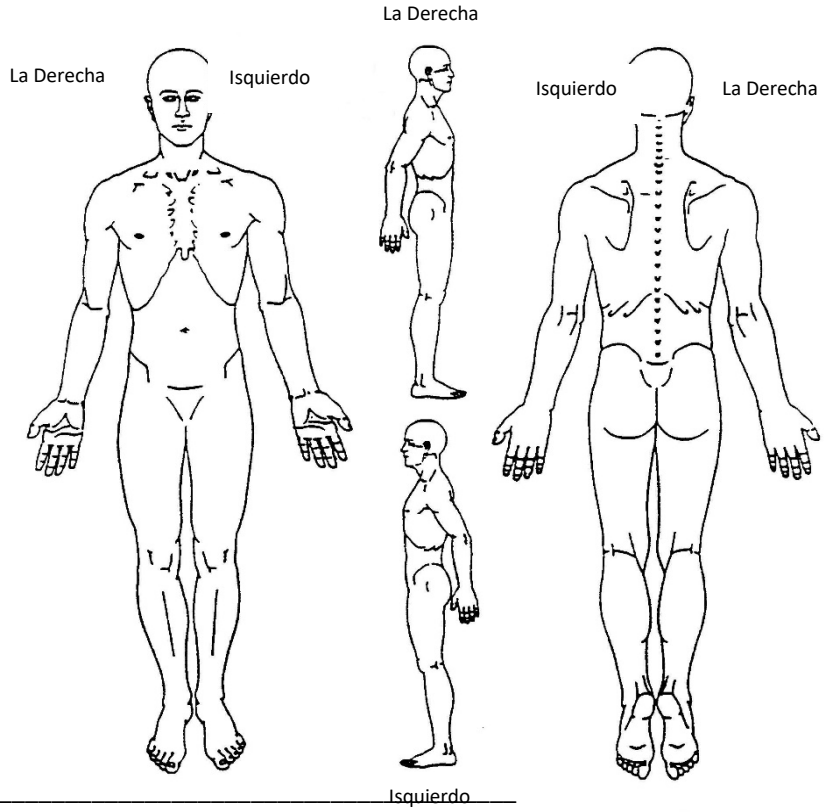
_____
_____



Que esperas ganar de terapia fisica? _____

HISTORIAL MEDICO PASADO *Tiene <u>actualmente</u> o tiene un <u>historial</u> de cualquiera de los siguientes:*

☐ Cardiopatia	☐ Alzheimer's	☐ Incontinencia
☐ Dolor en el pecho	☐ Parkinson's	☐ Cancer
☐ Accidente cerebrovascular	☐ Fibromialgia	☐ Hepatitis, tuberculosis, HIV, AIDS
☐ Insuficiencia cardiaca congestiva	☐ Enfermedad neurologica	☐ Fumador
☐ Ataque al corazon	☐ Convulsiones	☐ Enfermedad pulmonar obstructiva cronica/Enfisema
☐ Hipertension	☐ Ansiedad/problemas de panico	☐ Infeccion actual
☐ Coagulos de sangre	☐ Depresion	☐ Asma
☐ Enfermedad vascular periferica	☐ Lesion cerebral traumatica	☐ Alergias
☐ Problemas de la vista/de los ojos	☐ Dolores de cabeza	☐ Actualmente embarazada
☐ Problemas de la audicion	☐ Migranas	☐ Otro _____
☐ Obesidad	☐ Diabetes Tipo I o II	_____
☐ Artritis	☐ Problemas renales	_____
☐ Osteoporosis (huesos debiles)	☐ Problemas de prostata o vejiga	_____

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PATIENT AUTHORIZATION

- ✓ **Payment** of your deductible and co-pay amount is required at time of service. We accept check, cash and credit cards. We will file Medicare, primary and secondary insurance if all information is furnished to us. Should financial problems arise, we encourage you tocontact our office for assistance in the management of your account. Financial arrangements can be made; we are here to help you.

- ✓ **Insurance is a contract between you and your insurance company**. We are not a party to this contract. We will file claims onyour behalf from the information that you furnish us. If payment is made directly to you from your insurance you are responsiblefor sending us that payment.

- ✓ **I authorize CPR to release my records** to my insurance company, my referring physician and my attorney. I understand thatthese records will be held in strict confidence and will not be released to any unauthorized person.

- ✓ **I authorize payment** of medical benefits to undersigned physician or supplier for services rendered. Please let us know if you haveany questions or concerns. Your signature below signifies your understanding and willingness to comply.

- ✓ **I give Center for Physical Rehabilitation my consent** to perform physical therapy services according to the recommended planof treatment as discussed by my therapist.

- ✓ **HIPPA notification**: Our Notice of Privacy Practices describes how Center For Physical Rehabilitation, LLC may use and disclose protected health information. It also describes rights to access and control of protected health information. "Protected health information" is information about a person, including demographic information that may identify a person and that relates to their past, present or future physical or mental health or condition and related health care services. CPR, its employees, business associates and contractors are required to abide by the terms of this Notice of Privacy Practices. A full copy of our policyis available to you at any time. By signing below, you are giving us permission to disclose in written, electronic and oral formats as it is related to your medical needs, insurance requirements and payments to your account.

_____ _____

SIGNATURE **DATE**

CPR will not discriminate on the basis of Race, Color, Religion, National Origin, Handicap or Age.

PARENTAL CONSENT NEEDED IF **PATIENT IS UNDER THE AGE OF 18**

I hereby give my consent as a Parent/Guardian of_____for physical therapy evaluation and treatments rendered by the Center for Physical Rehabilitation. (sign here)_____.

The Center for Physical Rehabilitation offers a wide variety of services. If you would be interested in services other than what you were referred for, please ask your therapist for more information.

- Adaptive Equipment Needs
- Pediatric Therapy
- Aquatic Exercise Program
- Weight Loss/Exercise Program
- Wound And Burn Care
- Sports Performance
- Amputee Program
- Pre/Post Partum Program
- Home Safety Evaluation
- Neurological Rehab, For Stroke Or Brain Injury
- Incontinence Management
- Post Offer Job Screens
- Ergonomic Assessment
- TMJ / Headaches
- Hand Therapy