AFFINITY
HEALTH GROUP

Patient Health History and Information

Name: ____________ Date: ______
DOB: ______ Patient ID: ______
Insurance: ____________

Date: ___ / ___ / ___ Sex: M F Age: ____ Height: _____ Weight: _____ Dominant hand: R L

*Are you currently receiving home health services? YES NO

Is there any chance that you could be pregnant? Yes No Reason for Therapy: ____________

Please describe how your injury/problem occurred (i.e. fall, activity, work, auto, unknown): ____________

Date of injury or onset of symptoms: ___ / ___ / ___ Recent surgery? Yes No Date: ___ / ___ / ___ Type: ______

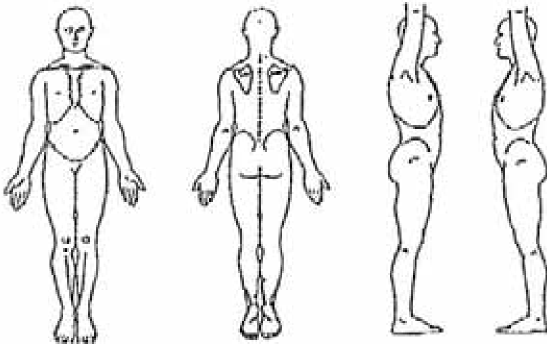
Please list any treatment you have received for this condition (i.e. Therapy, Chiropractor): ____________

For this condition have you had any of the following? None X-ray ___ / ___ / ___ MRI / CT Scan ___ / ___ / ___

Injection: type: ______ / ___ / ___ Surgery: type: ______ / ___ / ___ Other: ______ ___ / ___ / ___

Using the key below indicate on the body diagrams where your symptoms are located.

X = Pain // = Numbness O = Tingling



Please rate your pain (0 = none, 1 = minimal, 10 = severe)											
At present:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Please describe your pain / symptoms
Constant Intermittent Increasing Decreasing Staying the same
Sharp Dull Aching Burning Weakness Throbbing Other: ______

Which side are we seeing you for? Right Left

What makes your symptoms worse? (i.e. heat, cold, rest, activity) ____________

What makes your symptoms better? (i.e. heat, cold, rest, activity) ____________

Please indicate your current limitations due to injury:

___ Sitting	___ Standing	___ Sleeping
___ Going from sit to stand	___ Walking	___ Lying down
___ Reaching	___ Squatting	___ Bending
___ Taking a deep breath	___ Swallowing	___ Talking / Chewing / Yawning / All (circle one)
___ Turning head	___ Driving	___ Work
___ Self-care / Hygiene	___ Up / Down stairs	___ Home activities
___ Repetitive activities	___ Looking overhead	___ Sports / Recreation

___ Other: ____________

What are your goals for therapy? ____________

Since your symptoms began have you had any of the following?

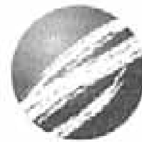
Fever / Chills	Yes No	Unexplained weight change	Yes No
Nausea / Vomiting	Yes No	Night sweats / pain	Yes No
Numbness genital / anal area	Yes No	Problems with vision / hearing / speech	Yes No
Dizziness / Fainting	Yes No	Difficulty with bowel / bladder function	Yes No
Unexplained weakness	Yes No	Other: ______	Yes No
Headaches	Yes No		

Who referred you to Physical Therapy / Occupational Therapy? ____________

Primary Physician: ____________

How did you hear about Affinity? Physician Friend/Relative Website Previous patient Self Coach Other

GENERAL HEALTH HISTORY:



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Have you had any falls or near falls in the past year? __________ Yes __________ No

Rate your overall health: Excellent Good Average Poor **Do you exercise?** Yes No _____ x/week

Do you smoke? Yes No **Do you drink caffeinated beverages?** Yes No _____ x/week

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Occupation/Job Title: ______________________ Self Student Full time Part time Retired Unemployed

Living Situation: Alone Spouse Family Others

Physical activities at work: Sitting Standing Computer use Phone use Repetitive/Heavy lifting Other: _________

Employer:______________________ **Current Work Duty:** Full duty Restricted duty **Work days missed:**_______

Have you or anyone in your immediate family (parents, siblings, grandparents) **ever been diagnosed with any of the following:**

Condition				Condition			
Allergies/asthma	Self	Family	No	Kidney problems	Self	Family	No
Cancer	Self	Family	No	Thyroid problems	Self	Family	No
High blood pressure	Self	Family	No	**Epilepsy/dizziness/light headed**	Self	Family	No
Heart trouble/angina	Self	Family	No	Tuberculosis	Self	Family	No
Diabetes	Self	Family	No	Anemia/blood disorder	Self	Family	No
Stroke	Self	Family	No	Multiple Sclerosis	Self	Family	No
Osteoporosis	Self	Family	No	Circular/vascular problems	Self	Family	No
Osteoarthritis	Self	Family	No	Chemical Dependency	Self	Family	No
Rheumatoid arthritis	Self	Family	No	***PACEMAKER**	Self	Family	No
Depression	Self	Family	No	AIDS/HIV	Self	Family	No
Headaches	Self	Family	No	Hepatitis	Self	Family	No
Bladder/bowel problems	Self	Family	No	Other:____________________	Self	Family	No

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Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest in the pleasure of doing things: 0- Not at all 1- Several Days 2- More than half the days 3- Nearly every day

Feeling down, depressed or hopeless: 0- Not at all 1- Several Days 2- More than half the days 3- Nearly every day

Are there any other issues/concerns that you think we should know about that may or may not affect your ability to benefit from physical/occupational therapy treatment: ________ Yes ________ No ______________________________

____

____

Patient Signature: ____ **Date** _______/_______/_______

Reviewed by Therapist: ____ **Date** _______/_______/_______

MD follow-up: _______/_______/_______ ☐ None Scheduled

With-in 90 days of last Medical History completion (date and initial any changes)

- Medical History reviewed by patient, changes noted and reviewed by therapist.

Patient Signature: ____ **Date** _______/_______/_______

Reviewed by Therapist: ____ **Date** _______/_______/_______

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Patient Name:	Date of Birth:	Date Completed:
Allergies/Adverse effects to medications:		

1. In order to provide optimal care it is important for us to maintain an up-to-date list of all your medications.
2. Please fill out the chart below.

**** If you already have a complete list of your medications, please bring it and we will make a copy in lieu of completing this form.****

Are you an established Affinity patient? Yes ☐ No ☐

Name of prescription medication (brand or generic)	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc.)
Example: Lasix	*20 mg.*	*High blood pressure*	*Two times a day*	*By mouth*

Over the Counter medication or nutritional supplements	Dosage	Why are you taking this medicine?	How often do you take it?	How do you take it? (by mouth, injection, etc.)

Physical/Occupational Therapy Informed Consent & Liability Release

I have been informed of and acknowledge that participation in physical exercise involving flexibility, strength, balance, agility, and aerobic exercise, including the use of equipment and devices, is a potentially hazardous activity. I have also been informed of and acknowledge that participation in physical therapy and/or occupational therapy can be a test of a person's physical and mental limits and that such participation and training poses potential risks of serious bodily injury or death.

I HEREBY ACCEPT THE RESPONSIBILITY FOR ANY HARM, INJURY, OR DAMAGE THAT MAY RESULT FROM MY PARTICIPATION IN PHYSICIAL THERAPY AND/OR OCCUPATIONAL THERAPY TREATMENT.

I HEREBY WAIVE, RELEASE, ABSOLVE, INDEMNIFY, AND AGREE TO HOLD HARMLESS AFFINITY HEALTH GROUP, LLC AND ITS MANAGERS, OFFICERS, EMPLOYEES, AGENTS, AND AFFILIATES FOR ANY CLAIM OR LOSS ARISING OUT OF OR RELATED IN ANY MANNER TO ANY INJURY INCURRED BY ME WHILE PARTICIPATING IN PHYSICIAL THERAPY AND/OR OCCUPATIONAL THERAPY TREATMENT, WHETHER THE RESULT OF NEGLIGENCE OR ANY OTHER CAUSE. I VOLUNTARILY AND KNOWINGLY ACKNOWLEDGE, ACCEPT, AND ASSUME THESE RISKS.

I have read and understand this "Physical/Occupational Therapy Informed Consent & Liability Release" (hereafter referred to as the "Waiver &Release"). I am aware that this Waiver & Release constitutes a full and complete release of liability by me and if I am signing on behalf of my minor child or as an appointed agent on behalf of someone this is a full and complete release on behalf of that individual. I acknowledge that I am signing this Waiver & Release of my own free will, with full knowledge of the risks being assumed.

I acknowledge the following:

1. Affinity Health Group, LLC (hereafter referred to as "Affinity") consists of a group medical practice. Affinity is wholly owned by Vantage Health Plan, Inc. (hereafter referred to as "Vantage"). Vantage is a duly licensed health maintenance organization which is owned, in part, by physicians practicing in Northeast Louisiana.
2. Vantage's Medical Directors reserve the right to request that an enrollee in one of Vantage's health plans undergo a physical therapy evaluation and/or an occupational therapy evaluation at its case management clinics located within Health Management Center or at The Abraham Medical Clinic in Mangham, Louisiana to determine the need for and/or continuation of physical therapy and/or occupational therapy services by the enrollee's current healthcare provider.
3. If I am an enrollee in one of the health plans offered by Vantage, I am under no obligation to receive physical therapy and/or occupational therapy services from Affinity.

I agree to the following:

1. My participation in physical therapy and/or occupational therapy treatment is strictly voluntary.
2. My participation in each and every exercise and activity within the physical therapy and/or occupational therapy training program is voluntary and I may choose not to participate, or to limit my participation, in any exercise or activity at any time.
3. I am personally responsible for my own safety while participating in the physical therapy and/or occupational therapy program. I will pace myself to maintain a level of participation that is safe and comfortable to me.
4. I will advise the Affinity physical therapist and/or occupational therapist, as applicable, of any changes in my physical or mental health prior to participation in each session.
5. I will ask questions and raise any concerns that I might have regarding my participation in the physical therapy and/or occupational therapy program with the Affinity therapist(s).

Patient's Name (Print) ______________________

Patient's Signature ______________________ Date