DIVERSIFIED
Rehabilitation Services

First Name: _____ Middle Name: _____ Last Name: _____

Address:_____ Apt/Unit:_____

City:_____ State:_____ Zip::_____

Date of Birth: ____/____/_____ Gender: _____ Last 4 of Social Security #: ____ ____ ____

Home Phone #: _____ Cell #: _____E-Mail: _____

Emergency Contact: _____ Phone#:_____ Relationship:_____

Primary Doctor:_____ Phone #: _____

Referring Doctor:_____ Phone #: _____

Do you have a follow-up scheduled at your referring physician? ___Y ___N If yes, when:_____

Do you live in a Skilled Nursing or Assisted Living Facility, or Rehab Center? Y _ N_ name/phone:_____

Consent for Treatment

The patient/legal guardian authorizes The American Institute of Balance staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Consent to Release Medical Information

I authorize Diversified Rehabilitation Services to release any information acquired in connection with my diagnostic/treatment services including, but not limited to, diagnosis & clinical records, to myself, my insurance(s), physician(s), and _____

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Diversified Rehabilitation Services.

Primary Insurance Name _____ ID # _____ Group # _____

Primary Insurance Card Holder Name _____ Primary Card Holder Date of Birth ___ / ___ / ___

Secondary Insurance Name _____ ID # _____ Group # _____

Initials

Guarantee of Payment: I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when a patient does not call to cancel an appointment, he/she is preventing another patient from getting much needed assistance. Out of this necessity, if an appointment is not cancelled by 4 PM the day preceding the scheduled appointment, a twenty-five dollar ($25) fee will be charged; this will not be covered by your insurance company. Thank you for understanding

I hereby certify that I understand these rights as set forth

I acknowledge that I have been informed of Diversified's Privacy Practices as required by the Health Insurance Portability And Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information. A current copy of our Privacy Practices is available to you upon request. I further understand that I am concenting to receive emails and/or voice message unless otherwise stated.

Client/Responsible Party Signature: _____Date:_____

Legal Representation (If applicable): Name:_____ Signature:_____

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Patient Name: _____

Date: _____

Past Medical History

Do you have, or have you had, any of the following?

Neurologic

- □ Migraine
- □ Stroke/TIA
  - If so, when? _____
- □ Parkinson's Disease
- □ Seizures/ Epilepsy
- □ Concussion/Head Injury
  - If so, when? _____
- □ Multiple Sclerosis
- □ Alzheimer's
- □ Other Neurologic _____

Cardiovascular

- □ Heart Attack
  - If so, when? _____
- □ Pacemaker
- □ Peripheral Arterial Disease
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Other Cardiovascular_____

Respiratory

- □ Breathing Difficulties
- □ Emphysema/COPD
- □ Asthma
- □ Other Respiratory _____

Other Health Issues:

_____

_____

_____

_____

Orthopedic

- □ Artificial Joints
  - If yes, which?_____
- □ Arthritis
- □ Back Problems
- □ Back Surgery
  - If so, when? _____
- □ Neck Problems
- □ Osteoporosis/Osteopenia
- □ Other Orthopedic_____

Vision

- □ Cataracts
  - If removed, when?_____
- □ Glaucoma
- □ Macular Degeneration
- □ Other Vision _____

Other

- □ Cancer
  - Type: _____
- □ Diabetes
- □ Neuropathy
- □ Depression
- □ Anxiety
- □ Thyroid
- □ Gastrointestinal Problems
- □ Rheumatoid Arthritis
- □ Tobacco Use
  - If yes, how much?_____
- □ Alcohol Use
  - If yes, how much?_____

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Patient Name: _____

Date: _____

Please list all of your **current medications and supplements**

Prescription	Dosage	Frequency	Route	Reason

Over the counter	Dosage	Frequency	Route	Reason

Supplements & Vitamins	Dosage	Frequency	Route	Reason

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SPEECH AND LANGUAGE PATHOLOGY INTAKE FORM (ADULT)

Name: _____ Date of Birth: _____ Date: _____
Please answer the following questions to the best of your ability:
1. What problem brings you to speech and language therapy? (check all that apply and write in date diagnosed):
□ Stroke _____ □ TIA _____ □ Swallowing Difficulty _____
□ Traumatic Brain Injury _____ □ Aphasia _____
□ Dysarthria/Apraxia _____ □ Facial Weakness _____
□ Cancer: □ Head/Neck____ □ Jaw_____ □ Mouth____ □ Throat _____ □ Other:
_____
Speech:
2. Have you had a speech and language evaluation at another clinic? □ No □ Yes
Name of clinic: _____

Address: _____

Date of evaluation: _____

3. Have you received previous Speech Therapy? □ No □ Yes
When? _____ Where? _____For how long? _____
Therapist's Name: _____

4. What was the focus of your previous Speech Therapy? _____

_____

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5. Have you had any current: X-Rays? □ No □ Yes, Date _____ Where _____ CT Scans?
□ No □ Yes, Date _____ Where _____

6. What was your prior level of communication?
□ Independent □ Need assistance some of the time □ Maximum assistance to communicate

7. Current Level of Communication: I can express basic needs or wants:
□ No □ Yes: How: □ verbal □ writing □ single words □ sentences □ pointing/gestures

10. Do you still participate in your hobbies? □ No □ Yes _____
11. List Family Member names and relationship: _____
_____ _____ _____
_____
Swallowing:
13. Have you ever been evaluated for a swallowing problem? □ No □ Yes
If yes, by whom? _____

What were the recommendations? _____
_____
14. Are you currently on a modified diet? □ No □ Yes
If Yes, what are the details of your diet modifications? _____
_____
15. What is your goal for Speech/Swallow Therapy? _____
_____

I certify the above information is true to the best of my knowledge and ability.

_____
Patient/Representative Print Name

_____
Date