KINECT REHAB

PHYSICAL REHABILITATION & HUMAN PERFORMANCE

Scheduling & Billing: 740.462.8604
789 Hebron Road, Suite E, Heath, OH 43056

NAME: _____

CLINICAL INFORMATION

What is the reason for your visit in the order of importance to you?

1) _____
2) _____
3) _____
4) _____

What are your treatment goals (please circle all that apply)

Pain/Symptom Relief	Sport Motion Assessment	Increased/Corrected Joint Movement
Post-Surgery Rehab	Improve Everyday Activity	Symptom Relief of Chronic Condition
Consult / 2nd Opinion Only	Ergonomic Assessment	Car Accident Recovery

What surgery/surgeries have you had previously? (provide dates) _____

What conditions do you have or have had in the past? (diebetes, high blood pressure, cancer etc.)

What have you tried before coming to Kinect Rehab? (include other types of doctors and home care)

What has helped? _____

What other doctors are you currently seeing? _____

What activities are you wanting to resume?

By signing this, I give Dr. Derek Myers, D.C. and his staff permission to treat me and bill me or my insurance (if applicable) for any charges incurred. My signature below also acknowledges that I accept the incurred charges as my responsibility should insurance not be involved or my policy does not cover services at Kinect Rehab.

SIGN: _____ DATE: _____