



Patient Registration Form

First Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip code: _____ SS number: _____ Date of birth: _____

Home phone: _____ Cell phone: _____ SMS/Text on cell (circle) Yes No

E-mail address: _____ Work phone: _____

Please keep in mind that communications via email over the internet is not a secure form of communication.

Employer and Employer phone number: _____

Who is your General Physician: _____

2nd contact person name/address: _____

Phone Number: _____ Relation: _____

Please Fill Out the Following Information If Different from Above

Primary Policy holder information: _____ (name, address, Insurance plan name)

Policy holder DOB: _____ ID/SS#: _____ Group number: _____

Secondary Policy holder information: _____ (name, address, Insurance plan name)

Policy holder DOB: _____ ID/SS#: _____ Group number: _____

Have you received ANY Home Health or Hospice Services in the last 90 days? Yes No

Is this work related? Yes No If yes, Date of Injury: _____

Is this Motor Vehicle Accident related? Yes No If yes, State _____ and Date of accident: _____

Have you had ANY PT, OT, or chiropractic services THIS YEAR? Yes No

How did you hear about us? Physician Referral, who referred _____ Family or Friend

Industry Advertisement (please list) _____ Other (please list) _____

I hereby authorize and consent to treatments/services for myself, or on the behalf of the above-named patient, performed by the staff at Elite Physical Therapy and/or as directed by my referring physician. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been recommended. I assign medical benefits payable for these services directly to Elite Physical Therapy. I authorize the release of any medical or other information necessary to process claims for these services.

I understand that I am responsible for payment of any applicable co-payments, co-insurance, deductibles or non-covered services at the time of service, I certify that the above information is accurate and complete; in Medicare assigned cases Elite Physical Therapy participates in the Medicare program and accepts Medicare's allowed amount for covered services, less any co-pay, co-insurance, deductible or non-covered services. In signing this form I acknowledge I am responsible for the bill not paid by the insurance carrier. I understand that my health information will be used for treatment, payment and healthcare operations in accordance with the Notice of Privacy Practices.

By providing your contact information, you agree to receive information, such as appointment reminders, patient surveys and other information relating to your therapy services via the communication channels you provided above.

Patient/Legal Guardian Signature – relationship to the patient

Date

I acknowledge receipt of the Notice of Privacy Practices which provides information on how my Protected Health Information may be used or disclosed, if I have any questions I can contact the Compliance Department.

Initial

Patient name: _____ Acct #: _____

PATIENT HEALTH QUESTIONNAIRE			
Occupation:	Height:	Weight:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Leisure activities/hobbies:			
Are you? <input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed			
Where do you live? <input type="checkbox"/> Private home <input type="checkbox"/> Apartment/rented room <input type="checkbox"/> Assisted living/group home <input type="checkbox"/> Hospice <input type="checkbox"/> Other			
With whom do you live? <input type="checkbox"/> Alone <input type="checkbox"/> Spouse only <input type="checkbox"/> Spouse and others <input type="checkbox"/> Child <input type="checkbox"/> Other			
Does your home have? <input type="checkbox"/> Stairs, no railing <input type="checkbox"/> Stairs, railing <input type="checkbox"/> Ramps <input type="checkbox"/> Uneven terrain Please explain:			
How many times have you fallen in the past 12 months?		Did it result in an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? <input type="checkbox"/> Yes <input type="checkbox"/> No			
General Health Status, please rate your health. <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			

Please list any known allergies (including medications, latex, etc.) below:

Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.			
Name	Dosage	Frequency	Please indicate route
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other

Surgery / Hospitalization, please include date and reason.	

Are you currently experiencing any of the following?			
Nausea or Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pains (Angina)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Productive/chronic cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain wakes me at night	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent fever, chills, sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing loss/ringing in ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unusual weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue or myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint pain or swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained weight changes	<input type="checkbox"/> Yes <input type="checkbox"/> No

Patient name: _____ Acct #: _____

Have you been diagnosed with any of the following?			
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis, if yes, Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Auto Immune Disease If yes, Type:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metal Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel or Bladder Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer, If yes, Site:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peripheral Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal Cord Stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gall Bladder problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No

Social History / Wellness	
Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No
How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? <input type="checkbox"/> At least 3 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Seldom or Never	

Current Condition
When did this problem(s) first begin?
Describe the problem(s).
Explain how problem(s) occurred.
Have you ever had this problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times?
Are your symptoms worse in the: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Same all day
How are you taking care of the problem(s) now?
My pain/problem is slowing getting: <input type="checkbox"/> Worse <input type="checkbox"/> Better <input type="checkbox"/> Staying the same
My symptoms bother me: <input type="checkbox"/> Constantly (100%) <input type="checkbox"/> Most of the time (75%) <input type="checkbox"/> Occasionally (50%) <input type="checkbox"/> Once in a while (25%)
Do you have any numbness, tingling, or burning? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check one: <input type="checkbox"/> Constantly <input type="checkbox"/> Intermittently

Patient name: _____ Acct #: _____

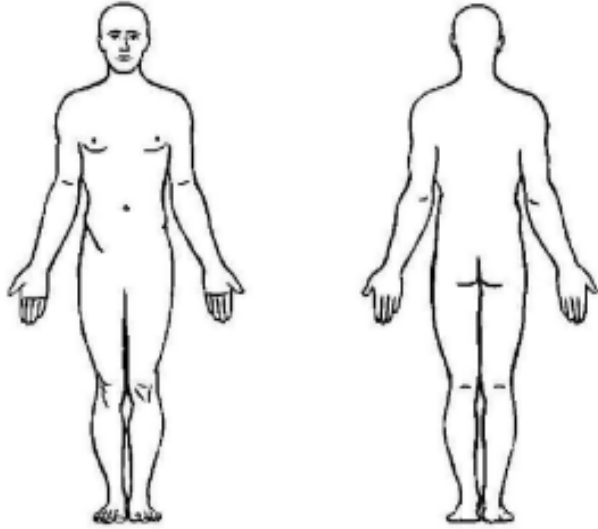
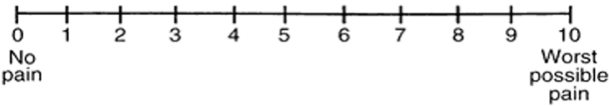
What functions could you perform before, that you now are unable to do?
Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.
Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.
Are you aware of any physical reason why you should not receive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please tell us what it is:
What are your goals for therapy?

Symptom Rating

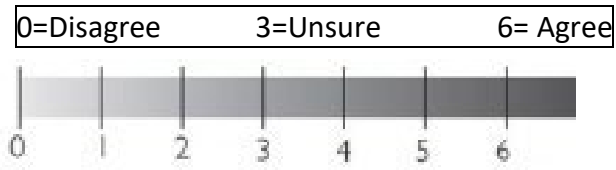
Mark location of symptom(s)
O for pain
X for numbness/tingling/burning

Please rate your pain - on a scale from 0 – 10
(0 = No Pain; 10 = Worst pain imaginable)

Current:	Best:	Worst:
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“I should not do physical activity which (might) make my pain worse”. Please rate your level of agreement on the scale below:



To the best of my knowledge the above information is accurate and complete.

Patient/Guardian signature _____ Date _____

Therapist signature _____ Date _____