FOCUS PHYSICAL THERAPY

PATIENT REGISTRATION

Confidential

PERSONAL INFORMATION

Name* _____ Date of Birth* _____ Age* _____

Address 1* _____ Gender* ◯ Male ◯ Female

Address 2 _____ Employer Name _____

City* _____ State* _____

Zip* _____

Phone Number* _____

Email* _____

APPOINTMENT REMINDER PREFERENCE

☐ Text
- ◯ Verizon ◯ AT&T
- ◯ Other: _____

☐ Email

☐ Call

EMERGENCY CONTACT

Name* _____

Relationship* _____

Phone Number* _____

REFERRAL INFORMATION

Referring Physician _____ Date of Last MD Visit _____

Who may we thank for your referral other than your Doctor?
- ◯ Yelp ◯ Google ◯ Facebook
- ◯ Family/Friend _____
- ◯ Other _____

DURING THIS CALENDAR YEAR, HAVE YOU HAD ANY OF THE FOLLOWING REHABILITATION SERVICES?

◯ Physical Therapy — For how many visits? _____

◯ Home Health Therapy — For how many visits? _____

◯ Speech Therapy — For how many visits? _____

INSURANCE INFORMATION

Insurance Carrier _____ Phone Number _____

Member ID _____ Group Number _____

Primary Subscriber Name _____ Subscriber DOB _____

Case Manager Name _____

Is your injury a result of a: ◯ Work Related incident? ◯ Motor vehicle accident?

Case Manager Phone _____

Briefly describe what will we be helping you with?

When did your condition start?

What makes it better?

What makes it worse?

How is your condition changing? ☐ Getting Better ☐ Not Changing ☐ Getting Worse

What percentage of day does it bother you? ○ 0% ○ 25% ○ 50% ○ 75% ○ 100%

What activites are limited by it?

Select other health professionals that you have seen for this ☐ MD ☐ Chiropractor ☐ Acupuncture ☐ Massage ☐ Personal Trainer ☐ Other

Where/When?

What tests have you had for it? ☐ X-Ray ☐ MRI ☐ CT ☐ EMG/NCV ☐ Other

Have you had 2 or more falls in the past year with or without injury? ○ Yes ○ No

Height (ft.) **Weight (lbs.)**

PERSONAL HEALTH HISTORY
GENERAL CURRENT CONDITIONS

Please read all and check all that apply to you

RECENT

- ☐ Accident
- ☐ Surgery
- ☐ Fall
- ☐ Whiplash
- ☐ Blow to Head
- ☐ Muscle Spasms
- ☐ Numbness / Tingling
- ☐ Radiating Pain
- ☐ Restricted Movement
- ☐ Spinal Disorder
- ☐ Shoulder / Arm / Hand problems
- ☐ Hip / Leg / Foot problems
- ☐ Head Aches
- ☐ Migraines
- ☐ Depression
- ☐ Anxiety
- ☐ Dizziness
- ☐ Vision problems
- ☐ Nausea
- ☐ Asthma / Breathing problems
- ☐ High Blood Pressure
- ☐ Convulsions / Epilepsy
- ☐ Heartburn / Acid Reflux
- ☐ Digestive problems
- ☐ Sleep problems
- ☐ Jaw / Mouth problems

DIAGNOSED CONDITION

- ☐ Born with Bone / Joint Disorder
- ☐ Degenerative Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Compression Facture
- ☐ Heart Attack Disorder
- ☐ History of Stroke or Aneurysm
- ☐ Cancer
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Gout
- ☐ Lupus
- ☐ Tuberculosis
- ☐ Hepatitis B or HIV Infection
- ☐ Thyroid or Hormone Disorder
- ☐ Osteoporosis / Osteopenia
- ☐ Immune Supression Treatment / Disorder from Chemotheraphy, Organ Transplant, drugs, etc.
- ☐ 3+ months Steroid Medication or Intravenous drugs (past or present)

Other Conditions:

SPECIFIC BODY PAIN

- ☐ Neck pain with difficult swallowing
- ☐ Extreme neck stiffness with pain or "electric shocks" in arms or legs when moving neck
- ☐ Numbness or tingling of hands or feet or radiating pain
- ☐ Leg pain with exercise
- ☐ Numbness of inner thighs
- ☐ Back pain with urinary problems
- ☐ Severe pain that interrupts sleep
- ☐ Constant pain that does not improve by changing positions or lying down

SPECIFIC CURRENT CONDITIONS

- ☐ Poor balance when walking or standing
- ☐ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ☐ Memory loss after injury
- ☐ Recent unexplained weight loss
- ☐ Recent progressive muscle weakness or shaking
- ☐ Recent or current fever over 102F
- ☐ Loss of bowel or bladder control
- ☐ Pregnant

Last menstrual period _____

PAIN RATING

Rate your pain at its...

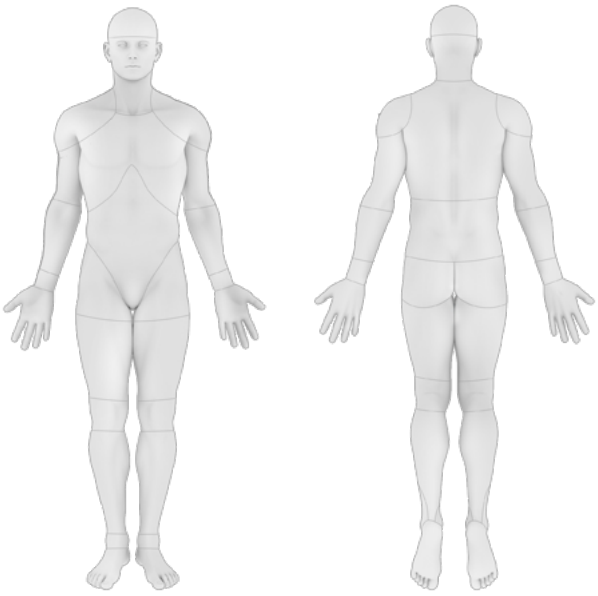
	0	1	2	3	4	5	6	7	8	9	10
Least:	○	○	○	○	○	○	○	○	○	○	○
Most:	○	○	○	○	○	○	○	○	○	○	○
Average:	○	○	○	○	○	○	○	○	○	○	○

List Surgeries and Dates

List Hospitalizations and Dates

List Current Medications and Supplements

PAIN DRAWING



OFFICE POLICY

☐ ATTENDANCE POLICY*

It is our goal to provide our patients with the highest quality of care while also attempting to accommodate our patients schedules for their convenience. Therefore, we provide reserved time slots for each patient in order to minimize our patients waiting time and assure continuity of treatment. Your consistent attendance of the planned treatment regimen is an important factor in your recovery.

While we are sensitive to the fact that emergencies may occur in rare instances, cancellations [especially those which are last minute] and missed appointments decrease our ability to accommodate the scheduling needs of other patients. Therefore, we require that our patients comply with the Cancellation and Missed Appointment Policy:

If you cancel a scheduled appointment less than twenty-four (24) hours prior to the scheduled appointment time, or if you do not arrive to the appointment at all, it will be considered a missed appointment and you will be charged a Missed Appointment Fee of $50.00;

☐ CONSENT TO EVALUATE AND TREAT*

I hereby request and consent to the performance of various modes of physical therapy on me (or the patient named below, for who I am legally responsible) by Focus Physical Therapy and/or other licensed physical therapists working at the clinic. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

☐ OUR PRIVACY POLICY*

The office of Focus Physical Therapy is committed to upholding the security and confidentiality of personal information that you provide to us. We take responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship.

I have been given a copy of the privacy policy of Focus Physical Therapy. I hereby authorize that my records of evaluation and treatment with the office of Focus Physical Therapy may be forwarded to referring physicians, specialists, or therapists, who are also involved in my healthcare. Your insurance claims will be transmitted through an electronic clearing house, in accordance with HIPPA regulations.

By agreeing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that my medical information above is correct to the best of my knowledge.

☐ PAYMENT POLICY*

Co-pay/Co-Insurance and Deductibles not met are due at time service is rendered. If you cannot settle your account at the time of each visit, special arrangements must be made in advance with our office.

I would like to keep a credit card on file, to be charged weekly, for any-co-pays or coinsurance owed by me. **(We accept Visa, MasterCard or Debit Cards).**
Please see Insurance Verification/Financial Agreement for your Benefit Details.

PLEASE CHARGE WEEKLY my co-pay or coinsurance to my _____ Card # _____

Name on Card: _____ Expiration Date _____ Security Code _____

Patient Signature* (parent/guardian if minor) _____ **Guardian Relationship*** _____

Patients Name* _____ **Date** _____