propel Physical Therapy

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PATIENT REGISTRATION

---> SAVE FORM AND OPEN IN ADOBE READER TO FILL OUT ELECTRONICALLY <---

Patient:	**Date:**

Street Address/PO Box:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Email:	D.O.B:	Social Security #:
Gender: Male ☐ Female ☐	Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐	
Employment: F/T ☐ P/T ☐ Unempl. ☐ Ret. ☐ Student ☐	Appt. Reminder Preference: Email ☐ Text ☐ Phone ☐	
Employer:	Occupation:	
Employer Address:		
Referring Doctor:	Primary Care Doctor:	
Emergency Contact Name:	Emergency Contact Phone:	

Primary Insurance Information		
Primary Insurance Company Name:		Phone:
Primary Insurance Company Address:		
Name of Insured:	ID #:	Group #:

Secondary Insurance Information		
Secondary Insurance Company Name:		Phone:
Secondary Insurance Company Address:		
Name of Insured:	ID #:	Group #:

Motor Vehicle Accident Injury Information		
Your Auto Insurance Carrier:		Phone:
Auto Insurance Carrier Address:		
Name of Insured:	Date of injury:	Claim #:
Adjuster Name:		

Job Related Injury Information		
Employer When Injured:		Date of Injury:
Employer's Workers Comp. Carrier:		Claim #:
Workers Comp Carrier Address:		
Workers Comp Carrier Phone:	Claim Status: Open ☐ Closed ☐ New ☐ Disputed ☐	

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PATIENT REGISTRATION

CONSENT TO PHYSICAL THERAPY (Please read before you sign)

1. CONSENT TO TREATMENT: I consent to rehabilitation and related services at Propel Physical Therapy. All procedures will be thoroughly explained to you before you are asked to perform them.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

2. TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

3. LIABILITY: I know and agree that Propel Physical Therapy is not responsible for loss or damage to personal valuables.

4. WAIVER AND RELEASE: I hereby release, discharge and acquit Propel Physical Therapy, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

5. AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to Propel Physical Therapy and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

Patient's Signature _____ Date _____

Signature of Responsible Party _____ Relationship to Patient _____

Date _____

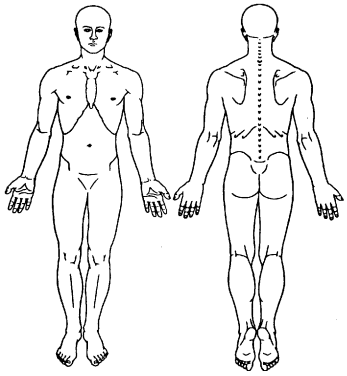
General Health Information

New patients and returning patients with a new injury/ concern must complete the following questionnaire

Patient Name: _____ Age: _____ Diagnosis or Problem Area: _____
When did your pain begin? _____ Specific incident _____ Multiple incidents _____ Gradually developed _____ No specific incident
Describe the "incident(s)" above, or how the injury occurred: _____
_____

Pain Diagram: Use the symbols below to mark the figures

Description:
^^^ = Aching
/// = Numbness
>>> = Stabbing
xxx = Burning
000 = Pins/ Needles
+++ = Throbbing



Frequency:
❑Sporadic (25% or less)
❑Occasional (26-50%)
❑Frequent (51-75%)
❑Constant (76-100%)

Is the pain getting: ❑Better ❑Worse ❑No Change

Have you had any of the following diagnostic tests for this injury?

❑Bone Scan
❑MRI
❑X-Ray
❑EMG/ Nerve Conduction Test
❑CT Scan
❑Other: _____

List your medications: _____
_____
_____
_____
_____
_____
_____

Please check as many of the following conditions that apply to you. Are you currently or have you ever experienced the following:

❑Chest Pain
❑Heart Attack
❑High Blood Pressure
❑Low Blood Pressure
❑High Blood Cholesterol (Hyperlipidemia)
❑Poor Circulation
❑Bleeding/ Bruising Problem
❑Blood Clots
❑Respiratory Disease
❑Difficulty Breathing/ Shortness of Breath
❑Head Injury
❑Surgeries: _____

❑Stroke
❑Seizures
❑Blackouts
❑Arteriosclerosis
❑Dizziness
❑Imbalance/ Frequent Falls
❑Cancer
❑Severe Night Pain
❑Night Sweats
❑Osteoporosis
❑Diabetes
❑Orthopedic Injuries: _____

❑Numbness to Hands or Feet
❑Visual/ Hearing Problems
❑Osteoarthritis
❑Tuberculosis
❑Rheumatoid Arthritis
❑Skin Rash/ Disease
❑HIV/ AIDS
❑Hepatitis
❑Smoking
❑Pregnancy
❑Bowel/ Bladder Problems

Rate your pain from 0-10 as follows:

0-1 No Pain
2-3 Mild Pain
4-5 Moderate/ Discomforting
6-7 Distressing/ Severe Pain
8-9 Intense/ Very Severe Pain
10 Severe/ Unbearable

Now: _____ **On average:** _____ **At its worst:** _____

What activities aggravate your injury/ problem area? _____
What activities relieve your injury/ problem area? _____
Is there any other information that you believe would assist the therapist in your care? _____
_____

_____ _____ _____
Patient Signature Parent/ Guardian Signature Date