**etc Physical Therapy PATIENT REGISTRATION**

(Please print)

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| Patient Name Home Phone Work/Cell Phone |
| Street Address City State Zip |
| Date of Birth Social Security Number Gender Marital Status |
| Occupation Employer Employer’s Address |
| Is your condition related to: ( If other, please describe )  Employment? Auto? Other? |
| If so, which state? Date of accident? |
| Whom may we thank for referring you to our practice? |

**Spouse or Responsible Party Information (If different from above)**

|  |
| --- |
| Name Home Phone Work/Cell Phone |
| Street Address City State Zip |
| Date of Birth Social Security Number Relationship to patient |
| Occupation Employer Employer’s Address |

**In Case of Emergency Contact**

|  |
| --- |
| Emergency Contact Name Home Phone Cell Phone |
| Relationship to Patient |

**Assignment & Release**

|  |
| --- |
| I, the undersigned, have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and assign directly to Exercise Therapy Consultants, Inc., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize ETC, Inc. to release all information necessary to secure the payment of benefits. I AUTHORIZE the use of this signature on all my insurance submissions whether manual or electronic.    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Insured/Guardian Date  **MEDICARE AUTHORIZATION**  I request that payment of authorized Medicare benefits be made either to me or on my behalf to Exercise Therapy consultants, Inc. for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Insured/Guardian Date  **WORKERS COMPENSATION**  I, the undersigned, have Worker’s Compensation benefits with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and assign directly to ETC, Inc., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I will be financially responsible for all charges if worker’s compensation benefits are denied. I hereby authorize ETC Inc., to release all information necessary to secure the payment of benefits. I AUTHORIZE the use of this signature on all my insurance submissions either electronic or manual.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Insured/Guardian Date |

**etc Physical Therapy** Patient History Form

|  |
| --- |
| Name Family Physician Referring Physician |
| Regarding this injury: Date of first Dr. visit? Last Date Worked? Date Returned to Work? |
| Did you have surgery for this injury? # of Surgeries? Type? Where/When |
| Are you aware of your diagnosis? (circle one) Based on your awareness, what are your expectations & or goals?  **YES NO** |
| Attorney’s Name (If applicable) Address Phone Number |
| List all medications your are currently taking (Prescription and/or Non-Prescription) |
| List any known allergies |
| Date of your next appointment with your Physician: Do you have any questions for your Physical Therapist? |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Chiropractor | Y | N |  |  | Neck injury/surgery | Y | N |
| **FOR THIS INJURY:** | General Practitioner | Y | N |  | Please indicate if | Shoulder injury/surgery | Y | N |
| have you had any of the | Myelogram | Y | N |  | you have had | Elbow injury/surgery | Y | N |
| following rehabilitative | Orthopedist | Y | N |  | previous orthopedic | Hand injury/surgery | Y | N |
| services? | Emergency Room | Y | N |  | injuries or | Back injury/surgery | Y | N |
|  | CT Scan | Y | N |  | surgeries. | Knee injury/surgery | Y | N |
|  | Massage Therapy | Y | N |  |  | Leg injury/surgery | Y | N |
|  | Neurologist | Y | N |  |  | Joint Replacement | Y | N |
|  | Physical Therapy | Y | N |  |  | Pins or metal implants | Y | N |
|  | X-Rays | Y | N |  |  | Other: | Y | N |
|  | EMG/NCV | Y | N |  |  |  |  |  |
|  | MRI | Y | N |  |  |  |  |  |
|  | Occupational Therapy | Y | N |  |  |  |  |  |
|  | Podiatrist | Y | N |  |  |  |  |  |
|  | Other | Y | N |  |  |  |  |  |

**Do you now have or have you ever had any of the following?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Asthma, Bronchitis, or Emphysema | Y | N | Osteoporosis | Y | N |
| Shortness of Breath/Chest Pain | Y | N | Gout | Y | N |
| Coronary Artery Disease | Y | N | Sleeping Problems / Difficulties | Y | N |
| Do you have a pacemaker? | Y | N | Emotional / Psychological Problems | Y | N |
| High Blood Pressure | Y | N | Bowel or Bladder Problems | Y | N |
| Heart Attack or Surgery | Y | N | Severe or Frequent Headaches | Y | N |
| Stroke / TIA | Y | N | Vision or Hearing Difficulties | Y | N |
| Blood Clot / Emboli | Y | N | Dizziness or Fainting | Y | N |
| Epilepsy / Seizures | Y | N | Numbness or Tingling | Y | N |
| Thyroid Trouble | Y | N | Weakness | Y | N |
| Infectious Diseases | Y | N | Weight Loss / Energy Loss | Y | N |
| HIV Positive | Y | N | Hernia | Y | N |
| Diabetes | Y | N | Varicose Veins | Y | N |
| Cancer / Chemotherapy / Radiation | Y | N | Do you Smoke? | Y | N |
| Arthritis / Swollen Joints | Y | N | Are you Pregnant? | Y | N |

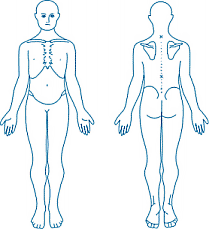
**Consent for Care & Treatment**

I, the undersigned, do hereby agree and give my consent for ETC Physical Therapy to furnish medical care and treatment to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_considered necessary and proper in diagnosing or treating his/her physical & mental condition.

Patient / Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| On the diagram, please indicate your current symptom location(s) using the key below: |

|  |  |
| --- | --- |
| Stabbing | //////// |
| Burning | XXXXXX |
| Numbness | ====== |
| Pins & Needles | 0000000 |
| Aching | SSSSSSS |



Place an (X) on the line at the point at which accurately describes the intensity of your pain now

Normal/No Pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Emergency/Extreme

How often do you experience your current symptoms? Always  Frequently  Occasionally  Seldom 

Using this scale (0 = No Pain, 10 = Emergency Pain):

I currently rate my pain at a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My **highest** pain level in the last 30 days has been \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My **lowest** pain level in the last 30 days has been \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Using this scale (0 = No Function, 10 = Able to Perform Daily Activities):

I currently rate my function at a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My **highest** function level in the last 30 days has been \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My **lowest** function level in the last 30 days has been \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR OFFICE USE ONLY**

I have reviewed the above information/conditions with patient/guardian prior to evaluation and treatment. The following was identified:

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have instructed the patient on their plan of treatment Y N

I have reviewed the patient’s rehabilitation potential prior to treatment Y N

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand and accept the treatment explained.

Patient/Guardian Signature