Outpatient Registration Form

Today's Date:	Last Name:	First Name:	Middle Init.	Gender

Maiden Name:	DOB:	Marital Status:	Race/Ethnicity:	Religion:

Social Security #:	Primary Care Physician:	What language do you wish to discuss your healthcare in?

Home Address	Apt #	City	State	Zip Code

Home Telephone #	Cell Phone #	Email Address _____
		☐ Check this box if you DO NOT want to be contacted via email regarding our services.

Employer's Name: _____	Employer's Telephone #
(Please check which applies) ☐ FT ☐ PT ☐ Unemployed ☐ Retired ☐ Student	

Primary Ins Holder/Sponsor's name and relationship:	Insurance company:
Date of Birth:	Holder/Sponsor's SSN:
Secondary Ins Holder/Sponsor's name and relationship:	Insurance company:
Date of Birth:	Holder/Sponsor's SSN:
Third Ins Holder/Sponsor's name and relationship:	Insurance company:
Date of Birth:	Holder/Sponsor's SSN:

Emergency Contact Name	Relationship	Home Telephone #	Cell Phone #

Emergency Contact Employer's Name	Work Telephone #

Clinic Patient ID sticker

InMotion Physical Therapy

Clinic Patient ID sticker

Name: _____ **Age:** _____

Have you had **surgery** for your condition? ☐ **Y** ☐ **N** If yes, please give date(s):_____

Have you had **injections** for your condition? ☐ **Y** ☐ **N** If yes, please give date(s):_____

Please list any **diagnostic tests** you have had for this condition: _____

Have you previously had, or are you currently receiving, any of the following services for your condition: physical therapy, chiropractic care, acupuncture, massage or personal training? ☐ **Y** ☐ **N**

What are your current symptoms? _____

Where is your pain or problem located? _____

When did the injury or symptoms occur? _____

How did the injury or problem occur? _____

Please rate your pain using a 0-10 scale (0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset _____ **Lowest** pain since onset _____ **Today's** pain _____

Is your pain? ☐ **Constant** ☐ **Intermittent**

What makes your pain/problem **better**? _____ **Worse**? _____

Is there pain present at night? ☐ **Y** ☐ **N** What position helps you sleep? _____

*** What do you hope to accomplish with therapy?** _____

Therapist's comments: _____

Have you had any recent **falls** (within past 3 months) ☐ **Y** ☐ **N** If yes, when? _____

Do you worry about falling? ☐ **Y** ☐ **N** Do you have dizziness? ☐ **Y** ☐ **N**

What type of **non-work** activities are you involved in? _____

When are you scheduled to see your doctor again? _____

How would you rate your overall health status (check one) ? ☐ **Poor** ☐ **Fair** ☐ **Good** ☐ **Excellent**

Would you like to speak with someone regarding **abuse or neglect** that you have recently experienced? ☐ **Y** ☐ **N**

Would you like to speak with someone regarding **suicide**? ☐ **Y** ☐ **N**

I consent to be treated in an open gymnasium atmosphere: ☐ **Y** ☐ **N**

If you marked "YES" - if at any time during the course of your therapy you would prefer to be treated in a more private area, please tell your therapist and they will make appropriate accomodations.

Employment History Are you currently working? ☐ **Y** ☐ **N** If no, how many total days of work have you missed? _____

Are your work duties ☐ **Restricted** ☐ **Full** How many hours per week do you work? _____

Who is your employer? _____

What type of work do you do? _____

What critical work duties have been most affected by your problem? _____

To the best of my knowledge and belief, the information I have given is complete and true. Please sign below.

**** Patient Signature:** _____ **Date:** _____ **Time:** _____

Therapist's comments: _____

Therapist signature: _____ **Date:** _____ **Time:** _____

Patient Name: _____ **DOB:** _____

Patient Summary List

Are you allergic to latex? ☐ YES ☐ NO

Do you have any known allergies? (drug or other) ☐ YES ☐ NO **if YES**, please list below:

Allergies or Drug Allergies	Reaction/Symptoms when allergy occurs	For Clinician Use Only If new, initial and date

☐ Check this box if you have brought a listing of your current medications and you will not have to complete the medication list below. Please give your list to our office staff to include in your chart.

☐ Check this box if you are NOT currently taking any medications.

Current Medication List (include OTC and herbal)	Dosage	Frequency	For Clinician Use Only New	D/C	Date/Initials

Medical History (check all that apply)

☐ Heart Disease	☐ Diabetes	☐ High Blood Pressure	☐ Asthma
☐ Fibromyalgia	☐ Tuberculosis	☐ Visual Impaired	☐ Epilepsy
☐ HIV/AIDS	☐ Arthritis	☐ Hearing Impaired	☐ Cancer
☐ Depression	☐ Pacemaker	☐ Latex Allergy	☐ Scoliosis
☐ Osteoporosis	☐ Thyroid Problems	☐ Pregnant	☐ Stroke
☐ Ehlers-Danlos synd.	☐ Alcohol Use	☐ Tobacco Use	☐ Hepatitis
☐ Multiple Sclerosis (MS)	☐ Other (please explain):		

☐ Weight change of more than 10 lbs recently

Additional/New Medical History	If new, Clinician Initial/Date	Surgical/Invasive Procedure History	Date of Procedure	If new, Clinician Initial/Date

**** Patient Signature:** _____ **Date:** _____ **Time:** _____

Therapist signature: _____ **Date:** _____ **Time:** _____

Clinic Patient ID sticker

5-2016

Personal Representative and Information Form

I,_____, authorize Bon Secours Outpatient Rehabilitation Services to release information about my medical care to:

_____ _____
(Relationship)

_____ _____
(Relationship)

I understand that I must notify Bon Secours Outpatient Rehabilitation Services in writing in order to terminate this designation. I also understand that Bon Secours Outpatient Rehabilitation Services is not responsible for information that is re-disclosed by the above named individual(s).

_____ _____ _____
(Patient's signature) (Date) (Time)

Date of Accident/Incident or Onset of Recent Symptoms	**Type of Incident:** ☐ **Auto** ☐ **Work** ☐ **No Accident** ☐ **Other:** _____

Preferred Communication:
☐ No Preference ☐ Do Not Contact ☐ Mail ☐ Phone

Would you like information in reference to financial assistance? ☐ Yes ☐ No

Do you have transportation issues which may prevent you from attending your therapy? ☐ Yes ☐ No

Advanced Directive Information:

Written Living Will for Medical Choices: ☐ Yes ☐ No *if yes*, location: _____

Written Medical Power of Attorney: ☐ Yes ☐ No *if yes*, name and location: _____

_____

Clinic Patient ID sticker

PATIENT'S RESPONSIBIILITIES

Welcome to In Motion Physical Therapy! Thank you for choosing this facility for your rehabilitation. We look forward to serving you with the highest quality of care available. The following information is to help ensure you and other patients, have an enjoyable therapy experience.

- If you need to **cancel or reschedule an appointment, please call us at least 24 hours in advance** so that we may open that appointment up to other patients.
- It is important for you to be on time for your appointments. **If you are late, your therapy session may be cut short, or we may have to reschedule your appointment**.
- **If you miss 3 appointments or more**, you may be **discharged from therapy** services and your physician will be notified.
- If you complete your treatment with us with a good attendance record, you will receive a gift upon discharge.
- Your therapist will give you some instructions/exercises for home. **It is important that you follow these instructions to achieve the maximum benefit from therapy**. Your family should be involved in your care if you require assistance at home.
- Periodically and upon completion of your therapy, we will send progress notes to your physician with recommendations. Together, your therapist, physician and you will decide when you have reached the maximum benefit from your rehabilitation. **Remember: Simply because your physician writes you a prescription for therapy does not guarantee payment from your insurance company**. We must show objective and functional improvement in an appropriate time frame; otherwise, we are mandated to discharge you from therapy.
- Please notify your therapist, the front office or another staff member if you are dissatisfied with your level of care so that we may remedy the situation.
- Out of respect for your privacy and that of other patients, please refrain from using your cell phone during your visit.
- For safety reasons, children are not permitted in the treatment area.

Thank you for giving us the opportunity to serve your rehab needs. We look forward to helping you achieve your goals and providing you excellent care.

_____ _____ _____

Patient Signature Date Time

Clinic Patient ID sticker

5-2016