

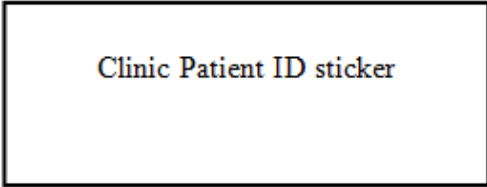


# Outpatient Registration Form

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 _____ <input type="checkbox"/> Check this box if you DO NOT want to be contacted via email regarding our services.			
Employer's Name: _____ <i>(Please check which applies)</i> <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student						Employer's Telephone #	
Primary Ins Holder/Sponsor's name <u>and</u> relationship:				Insurance company:			
Date of Birth:				Holder/Sponsor's SSN:			
Secondary Ins Holder/Sponsor's name <u>and</u> relationship:				Insurance company:			
Date of Birth:				Holder/Sponsor's SSN:			
Third Ins Holder/Sponsor's name <u>and</u> 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



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 accommodations.

**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.

<input type="checkbox"/> Check this box if you are NOT currently taking any medications.			For Clinician Use Only		
Current Medication List (include OTC and herbal)	Dosage	Frequency	New	D/C	Date/Initials

**Medical History (check all that apply)**

_____ Heart Disease	_____ Diabetes	_____ Weight change of more than 10 lbs recently
_____ Fibromyalgia	_____ Tuberculosis	_____ High Blood Pressure
_____ HIV/AIDS	_____ Arthritis	_____ Visual Impaired
_____ Depression	_____ Pacemaker	_____ Hearing Impaired
_____ Osteoporosis	_____ Thyroid Problems	_____ Latex Allergy
_____ Ehlers-Danlos synd.	_____ Alcohol Use	_____ Pregnant
_____ Multiple Sclerosis (MS)	_____ Other (please explain): _____	_____ Tobacco Use
		_____ Asthma
		_____ Epilepsy
		_____ Cancer
		_____ Scoliosis
		_____ Stroke
		_____ Hepatitis

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



### 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)

<b>Date of Accident/Incident <u>or</u> Onset of Recent Symptoms</b>	<b>Type of Incident:</b> <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> No Accident <input type="checkbox"/> Other: _____
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**Preferred Communication:**

No Preference    Do Not Contact    Mail    Phone

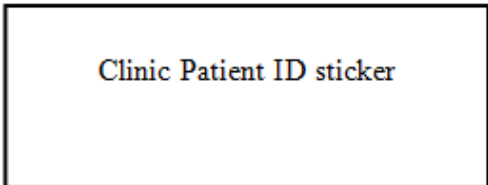
Would you like information in reference to financial assistance?    Yes    No

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: \_\_\_\_\_





PATIENT'S RESPONSIBILITIES



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

