

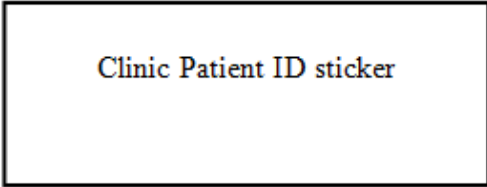


Outpatient Registration Form

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 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)

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

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)

Date of Accident/Incident <u>or</u> Onset of Recent Symptoms	Type of Incident: <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

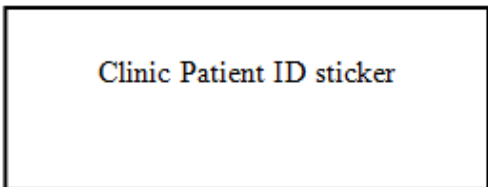
Would you like information in reference to financial assistance? Yes No

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 three or more appointments**, you may be **discharged from therapy** services and your physician will be notified.
- **Worker's Compensation patients**—all cancellations and no-shows will be documented and your adjuster/case manager and employer will be notified.
- 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, your 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.
- Therapy is performed in an open gym setting. Your therapist may use a curtained treatment area or a private treatment room if increased privacy is necessary.
- 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.

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