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

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 #

Nutrition Medical History/Subjective Information

Name: _____ **Date:** _____ **Birthdate:** _____ **Age:** _____

Height: _____ **Weight:** _____ **Referring Physician:** _____

Medical History (check all that apply)

☐	Eating Disorder	☐	Diabetes/Pre-Diabetes	☐	High Blood Pressure	☐	Stroke
☐	High Cholesterol	☐	Insulin Resistance	☐	Hypothyroidism	☐	GI Disorder
☐	HIV/AIDS	☐	Heart Disease	☐	Hyperthyroidism	☐	Cancer
☐	Depression	☐	Feeding Difficulties	☐	Failure To Thrive	☐	Pregnant
☐	Osteoporosis	☐	Constipation	☐	Food Allergies:_____		
☐	Weight Loss/Gain of more than 10 lbs recently				Other: _____		

Weight Loss of ten pounds or more within the last 6 months? ◯ **Y** ◯ **N** Was this intentional? ◯ **Y** ◯ **N**

Weight Gain of ten pounds or more within the last year? ◯ **Y** ◯ **N** Was this intentional? ◯ **Y** ◯ **N**

Dietitian's Comments: _____

Have you ever been **hospitalized** for a condition related to nutrition? ◯ **Y** ◯ **N** If yes, approximate date: _____

Do you take any medication for this condition? ◯ **Y** ◯ **N**

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

What are your current **nutritional concerns**? _____

What are **YOUR goals** for nutrition counseling? _____

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**

Employment/ School History

Are you currently working? ◯ **Y** ◯ **N** Are you currently in school? ◯ **Y** ◯ **N**

If yes to either above, have you missed any days of work or school due to a condition related to nutrition? ◯ **Y** ◯ **N**

How would you describe your ability to be active? ◯ **Restricted** ◯ **Full**

Do you do any exercise beyond daily living/work activities? ◯ **Y** ◯ **N**

If you do exercise, about many hours per week do you usually exercise? _____

What critical work/school activities (if any) have been most affected by the problem you are here for today? _____

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

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

Dietitian 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)

☐ Arthritis ☐ Asthma ☐ Scoliosis

☐ Fibromyalgia ☐ Tuberculosis ☐ Visual Impaired

☐ Multiple Sclerosis (MS) ☐ Epilepsy ☐ Hearing Impaired

☐ Ehlers-Danlos synd. ☐ Pacemaker ☐ Tobacco Use

☐ Hepatitis ☐ Alcohol Use

☐ Other (please explain): _____

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:** _____

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: _____

_____

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