# 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 __________<br>☐ Check this box if you DO NOT want to be contacted via email regarding our services. |
|---|---|---|
| | | |

| Employer's Name: __________<br>*(Please check which applies)* ☐ FT ☐ PT ☐ Unemployed ☐ Retired ☐ 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 # |
|---|---|
| | |

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| Clinic Patient ID sticker |
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Clinic Patient ID sticker

## InMotion Physical Therapy

**Name:** ______________________

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**

**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**

| Allergies or Drug Allergies | Reaction/Symptoms when allergy occurs | For Clinician Use Only If new, initial and date |
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❑ 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 |
| | | | | | |
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**Medical History (check all that apply)**

_____ Weight change of more than 10 lbs recently

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| _____ | 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): ______________________________ | | | | |

| Additional/New Medical History | If new, Clinician Initial/Date | Surgical/Invasive Procedure History | Date of Procedure | If new, Clinician Initial/Date |
|---|---|---|---|---|
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** Patient Signature: ______________________________ Date: ______________ Time: ______________

Therapist signature: ______________________________ Date: ______________ Time: ______________

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7-2022

# 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:** ______________ |
|---|---|

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

## General Communication Preferences

Please circle your preferred method for communication with our department. If you are not a current MyChart user, please ask our staff for more information. MyChart is our preferred method of communication for appointments and unexpected clinic closures. You can also view your medications, test results, medical bills, price estimates, and more all in one place.

| Communication | Mail | Phone | Text Message | Email | MyChart |
|---|---|---|---|---|---|
| **MyChart Account Management** | | | | | |
| **Appointments** | | | | | |
| **Billing** | | | | | |

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9-2021

Bon Secours

In Motion Physical Therapy

# 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

**A Department of Maryview Medical Center**

Approved by legal and risk management 6-2019