

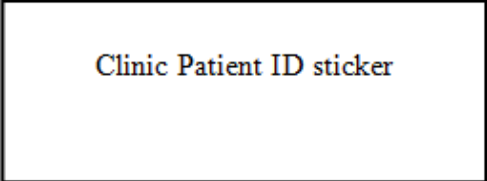


# Outpatient Registration Form



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 #	

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# Nutrition Medical History/Subjective Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

## Medical History (check all that apply)

<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Diabetes/Pre-Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Insulin Resistance	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> GI Disorder
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Cancer
<input type="checkbox"/> Depression	<input type="checkbox"/> Feeding Difficulties	<input type="checkbox"/> Failure To Thrive	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Constipation	<input type="checkbox"/> Food Allergies: _____	
<input type="checkbox"/> 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: \_\_\_\_\_

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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? \_\_\_\_\_

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## 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? \_\_\_\_\_

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***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: \_\_\_\_\_

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Clinic Patient ID sticker

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Patient Summary List**

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

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

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

- |  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Scoliosis        |
| <input type="checkbox"/> Fibromyalgia                  | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Visual Impaired  |
| <input type="checkbox"/> Multiple Sclerosis (MS)       | <input type="checkbox"/> Epilepsy     | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Ehlers-Danlos synd.           | <input type="checkbox"/> Pacemaker    | <input type="checkbox"/> Tobacco Use      |
| <input type="checkbox"/> Hepatitis                     | <input type="checkbox"/> Alcohol Use  |   |
| <input type="checkbox"/> 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:** \_\_\_\_\_

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### 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: _____

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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# 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.

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Patient Signature

Date

Time

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