PATIENT REGISTRATION FORM

NAME: _____ DOB: ___/___/___ SSN: _____-_____-____

ADDRESS: _____ CITY/STATE: _____ ZIPCODE: _____

PHONE: _____ MARITAL STATUS: M S D W If Minor Name of Guardian: _____

EMPLOYER: _____ JOB TITLE: _____

EMERGENCY CONTACT: _____ PHONE: _____

INSURANCE: _____ INSURED/GUARANTOR: _____ SELF/SPOUSE/PARENT

INSURED SSN: _____-_____-_____ INSUREDDOB: _____/_____/_____

ADDRESS: _____ CITY/STATE: _____ ZIPCODE: _____

INJURED AT WORK? Y N MOTOR VEHICLE ACCIDENT? Y N DATE OF INJURY: _____

ATTORNEY REPRESENTATION? Y N ATTORNEY'S NAME: _____

ATTORNEY ADDRESS: _____ CITY: _____ STATE: _____

ATTORNEY PHONE: _____

WORKER'S COMPENSATION CARRIER: _____ CLAIM #: _____

ADJUSTOR NAME _____ PHONE: _____

How did you hear about Whitestone Physical Therapy? _____
Would you like to receive appointment reminders by text or email? Y or N
Cell Phone: _____ AT&T SPRINT VERIZON TMOBILE VIRGINMOBILE (circle one)
Email Address: _____

Have you received any prior outpatient physical, occupational or speech therapy services or home health services this calendar year? Y or N If yes, when and what type? _____

Please Initial each line below:
_____I consent to rehabilitation and related services at WHITESTONE PHYSICAL THERAPY
_____I know and agree the CLINIC is not responsible for loss or damage to personal items
_____I acknowledge receipt of Notice of Privacy Practices
_____I consent to treatment of the minor child listed above (if applicable)
_____I authorize payment of medical benefits to CLINIC. I also authorize the release of medical records as necessary to process the medical claims. I understand that I am financially responsible for all charges incurred that are not covered in full by my insurance carrier.

_____ _____ _____
Signature of Patient/Guardian Date Witness Signature

PATIENT REGISTRATION FORM

CONSENT TO THE USE & DISCLOSURE OF HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

I consent to the use of disclosure of my protected health information by WHITESTONE PHYSICAL THERAPY for the purpose of providing my treatment, obtaining payment for my health care bills, or to conduct health care operations.

I understand and have been provided with a *Notice of Privacy Practice*, which provides a more complete description of how my protected health information may be used or disclosed. This notice also describes my rights and WHITESTONE PHYSICAL THERAPY'S duties with respect to my protected healthcare information. I understand that I have the right to review the notice prior to signing this consent.

I understand that WHITESTONE PHYSICAL THERAPY reserves the right to change their notice and information practices. I may obtain a copy of the revised notice by requesting that revised notice from the facility owner or office administrator.

I understand that I have the right to restrict how WHITESTONE PHYSICAL THERAPY uses or discloses my protected health information to carry out treatment, payment or health care operations; that WHITESTONE PHYSICAL THERAPY is not required to agree to a restriction that I may request and; that WHITESTONE PHYSICAL THERAPY is bound by the restrictions to which it agrees.

I understand that my requests for specific restrictions be submitted in writing, with this consent. Should I desire to make restrictions in the future, I realize that I may request those restrictions in writing and submitting them to the facility owner or office administrator.

I may be contacted by WHITESTONE PHYSICAL THERAPY to remind me of appointments and other health services that may be of interest to me.

Lastly, by signing this authorization you understand that a copy of the HIPPA Privacy Notice containing a detailed description of your rights, and the permitted uses and disclosures, under HIPPA will be given to you at your request.

Signature of patient: _____ Date: _____
(Or personal representative)

Name of patient (please print): _____

WHITESTONE
PHYSICAL THERAPY

Medical History Questionnaire

Name: _____ **Date:** _____

General Health Status

1. Currently, would you say your health is excellent, very good, fair or poor? _____
2. Have you sought previous treatment for this condition?

___ No other treatment	___ Psychiatrist/Psychologist
___ Massage Treatment	___ Chiropractor
___ Physical/Occupational Therapy	___ Other _____

3. Have you had physical therapy for other conditions in the past year? ___Yes ___No
   If yes, explain_____

Employment/Work

1.

___ Working without restrictions	___ Homemaker
___ Working with restrictions	___ Student
___ Unable to work due to dysfunction	___ other

2. Occupation_____
3. Is this a work-related injury? ___Yes ___No
4. Do you have an attorney representing you in this case? ___Yes ___No

Medical/Surgical History

1. **Please check if you HAVE HAD, or have any of the following:**

__ No known Significant PMH to affect treatment	__ HX of Cancer
__ Alzheimer's	__ Huntington's
__ Cardiovascular Disease	__ Immunosuppression
__ Cauda Equina Syndrome	__ Lupus
__ Cerebral Vascular Accident	__ Muscular Dystrophy
__ Current Infection	__ Obesity
__ Diabetes Mellitus Type 1	__ Osteoarthritis
__ Diabetes Mellitus Type 2	__ Parkinson's
__ Fibromyalgia	__ Traumatic Brain Injury
__ Fracture or Suspected Fracture	__ Other: _____
__ High Blood Pressure	

2. **Within the past year, have you had any of the following:**

__ Joint pain or swelling
__ Pain at night
__ Headaches
__ Weakness in arms/legs
__ Loss of balance
__ Difficulty sleeping
__ Chest pain
__ Bowel or bladder problem
__ Shortness of breath
__ Dizziness of blackouts
__ Cough
__ Hearing problem
__ Traumatic event
__ Weight loss/gain
__ Difficulty walking
__ Other: _____

3. Have you ever had surgery? ___Yes ___No If yes, please describe: _____

_____

4. Please list (or attach) a current list of medications: _____

_____

Current Condition / Chief Complaint

1. Please describe the problem for which you seek therapy_____

_____

2. What makes the problem(s) better? _____

_____

3. What makes the problem(s) worse? _____

_____

4. What are your goals for therapy? _____

_____

5. What is your pain level today?
(Low) 1 2 3 4 5 6 7 8 9 10 (high)
What is your pain level on average?
(Low) 1 2 3 4 5 6 7 8 9 10 (high)
What is your lowest level of pain?
(Low) 1 2 3 4 5 6 7 8 9 10 (high)
What is your highest level of pain?
(Low) 1 2 3 4 5 6 7 8 9 10 (high)

6. Any additional comments: _____

_____

_____

We look forward to serving your physical/occupational therapy needs here at
WHITESTONE PHYSICAL THERAPY.
Please let us know of any way we can better meet those needs.