FUNCTION PHYSICAL THERAPY

PATIENT REGISTRATION

Confidential

PATIENT DEMOGRAPHICS

Name:* _____ Date of Birth:* _____ Age _____

Parents or Guardian(if minor): _____ Gender:* ○ Male ○ Female

Marital Status: ○ Single ○ Married

Address:* _____

City:* _____ State:* _____

Zip:* _____

Email:* _____

Phone Number:* _____

EMERGENCY CONTACT

Name:* _____

Relationship:* _____

Phone Number:* _____

How did you hear about us? _____ Referring provider: _____

Do you have a provider prescription? ○ Yes ○ No

Do you authorize Function P.T. to discuss your treatment with your referring provider? ○ Yes ○ No

Next provider visit: _____

OCCUPATIONAL INFORMATION

Employer Name: _____ Currently Working: ○ Yes ○ No

Occupation: _____

INSURANCE INFORMATION

Primary Insurance Carrier:* _____

Member ID#: _____ Group #: _____

Primary Subcriber Name: _____ Date of Birth:* _____ Age _____

Secondary Insurance Carrier: _____

Member ID#: _____ Group #: _____

Secondary Subcriber Name: _____ Date of Birth:* _____ Age _____

HISTORY OF PRESENT CONDITIONS

Body Part/Region: _____ Side (if applicable): ○ Right ○ Left ○ Both

When did your symptoms begin? _____

Are your symptoms: ○ Constant ○ Intermittent ○ Improving ○ Worsening ○ Unchanging ○ Activity Dependent

Did you have surgery? ○ Yes ○ No If Yes, Date: _____ Type of Surgery: _____

How did you hurt yourself?:

What is your primary concern / chief complaints?

Have your received treatment for this before? ○ Yes ○ No Did it get better? ○ Yes ○ No

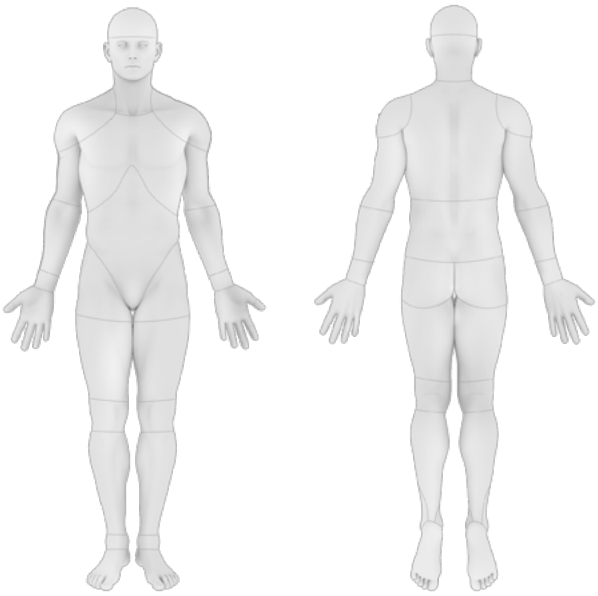
Where? _____ When? _____

Do your symptoms interrupt your sleep? ○ Yes ○ No

Does coughing, sneezing or taking a deep breath change your symptoms? ○ Yes ○ No

When is your pain the worst? ○ Morning ○ Night ○ At Rest ○ During Activy ○ After Activity

PAIN DRAWING



PAIN RATING (Please rate your pain in the scale below, circle the number that best represents your pain)

	Feel Great	Annoying	Nagging Pain	Hurts even more	Intense Horrible	Unbearable
Worst pain in the past 48 hours:	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Current intensity of pain:	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
Best pain in the past 48 hours:	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

What makes your pain worse?

What makes your pain better?

PATIENT MEDICAL SCREENING QUESTIONNAIRE

Do you smoke? ○ Yes ○ No Do you have a pacemaker? ○ Yes ○ No

Do you use a: ○ Cane ○ Walker ○ Wheelchair ○ Other _____

Women only: Are you currently pregnant or think you may be pregnant? ○ Yes ○ No

Past Medical History: (Please check all that apply.)

- ☐ Alzheimer's
- ☐ Cardiovascular Disease
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident
- ☐ Current Infection
- ☐ Diabetes Type I
- ☐ Diabetes Type 2
- ☐ Fibromylagia
- ☐ Fracture or Suspected Fracture
- ☐ High Blood Pressure
- ☐ History of Cancer
- ☐ Huntington's
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Traumatic Brain Injury
- ☐ Asthma
- ☐ Other _____
- ☐ If none apply check here

Please list any surgeries or other conditions, with dates, for which you have been hospitalized:

Please list any previous significant injuries and date:

Please list any diagnostic tests (x-rays, MRI, EMG, CT etc.) relevant to your current chief complaint and dates performed:

Have you RECENTLY noted any of the following: (Please check all that apply.)

- ☐ Fatigue
- ☐ Headaches
- ☐ Falls
- ☐ Dizziness
- ☐ Changes in Bladder/Bowel Function
- ☐ If none apply check here:
- ☐ Sudden Weight Loss/Gain
- ☐ Difficulty Walking
- ☐ Difficulty Swallowing
- ☐ Lightheadedness
- ☐ Shortness of Breath
- ☐ Loss of Balance
- ☐ Numbness/Tingling
- ☐ Muscle Weakness
- ☐ Depression
- ☐ Fever/Chills
- ☐ Nausea/Vomiting
- ☐ Constipation/Diarrhea
- ☐ Heartburn/Indigestion

Please list current medications, over the counter medication, vitamins, and supplements (include dosage and purpose):

If you are currently not taking any medications please check here: ☐

What are your goals or things you want to get back to doing?

CONSENT TO EVALUATE AND TREAT

I hereby request and consent to the performance of various modes of physical therapy on me (or the patient named below, for who I am legally responsible) by a licensed physical therapist employed by Function Physical Therapy, LLC. I understand as a patient, that Function Physical Therapy, LLC is not liable for any act when providing treatment in accordance of my physical condition. I acknowledge that no guarantee or assurance has been, nor can be, made by Function Physical Therapy, LLC as to the result of the prescribed treatment. By signing this agreement, I confirm that I have read and fully understand this consent form and I understand this consent may be revoked by me at any time

OUR PRIVACY POLICY

Function Physical Therapy is committed to upholding the security and confidentiality of personal information that you provide to us. We do not share or sell patient information with anyone outside of our office without your written consent. This covers information including personal, financial or health information.

I understand that under the Health Insurance Portability and Accountability Act (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment directly and indirectly, obtain payment from third party payers and conduct normal healthcare operations such as quality assessments and physicians' certification. I acknowledge that the notice of privacy policies was provided to me to be read and give authorization to Function Physical Therapy, LLC to use and disclose my protected health information for the uses listed to me.

By agreeing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that me medical information above is correct to the best of my knowledge.

Patient's Initials:* (parent/guardian if minor) _____ Guardian Relationship: _____

Full Name:* _____ Date: _____