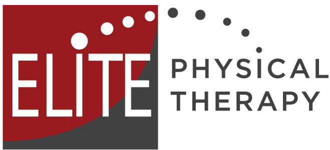


Patient Registration Form

First Name: ______________________ MI: ______ Last Name: ______________________

Address: ______________________________________ City: ____________________

State: ________ Zip code: ____________ SS number: ________________ Date of birth: ____________

Home phone: ______________ Cell phone: __________________ **SMS/Text on cell (circle) Yes No**

☐ E-mail address: ______________________________ Work phone: ________________

Please keep in mind that communications via email over the internet is not a secure form of communication.

Employer and Employer phone number: ____

Who is your General Physician: ____

2nd contact person name/address: ____

Phone Number: ______________________ Relation: ______________________

Please Fill Out the Following Information If Different from Above

Primary

Policy holder information: ____
(name, address, Insurance plan name)

Policy holder DOB: ____________ ID/SS#: ________________ Group number: ________________

Secondary

Policy holder information: ____
(name, address, Insurance plan name)

Policy holder DOB: ____________ ID/SS#: ________________ Group number: ________________

Have you received ANY Home Health or Hospice Services in the last 90 days? Yes No

Is this work related? Yes No **If yes,** Date of Injury: ______________________

Is this Motor Vehicle Accident related? Yes No **If yes,** State ________ and Date of accident: ____________

Have you had ANY PT, OT, or chiropractic services THIS YEAR? Yes No

How did you hear about us? ☐ Physician Referral, who referred ____________________ ☐ Family or Friend

☐ Industry ☐ Advertisement (please list) ______________ ☐ Other (please list) ______________

I hereby authorize and consent to treatments/services for myself, or on the behalf of the above-named patient, performed by the staff at Elite Physical Therapy and/or as directed by my referring physician. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been recommended.
I assign medical benefits payable for these services directly to Elite Physical Therapy. I authorize the release of any medical or other information necessary to process claims for these services.
I understand that I am responsible for payment of any applicable co-payments, co-insurance, deductibles or non-covered services at the time of service, I certify that the above information is accurate and complete; in Medicare assigned cases Elite Physical Therapy participates in the Medicare program and accepts Medicare's allowed amount for covered services, less any co-pay, co-insurance, deductible or non-covered services. In signing this form I acknowledge I am responsible for the bill not paid by the insurance carrier.
I understand that my health information will be used for treatment, payment and healthcare operations in accordance with the Notice of Privacy Practices.
By providing your contact information, you agree to receive information, such as appointment reminders, patient surveys and other information relating to your therapy services via the communication channels you provided above.

Patient/Legal Guardian Signature – relationship to the patient ______________________ Date ______________

Initial______ I acknowledge receipt of the Notice of Privacy Practices which provides information on how my Protected Health Information may be used or disclosed, if I have any questions I can contact the Compliance Department.

Patient name: ____ Acct #: ____________________________

PATIENT HEALTH QUESTIONNAIRE			
Occupation:	Height:	Weight:	Sex: ☐ Male ☐ Female
Leisure activities/hobbies:			
Are you? ☐ Right-handed ☐ Left-handed			
Where do you live? ☐ Private home ☐ Apartment/rented room ☐ Assisted living/group home ☐ Hospice ☐ Other			
With whom do you live? ☐ Alone ☐ Spouse only ☐ Spouse and others ☐ Child ☐ Other			
Does your home have? ☐ Stairs, no railing ☐ Stairs, railing ☐ Ramps ☐ Uneven terrain Please explain:			
How many times have you fallen in the past 12 months?		Did it result in an injury? ☐ Yes ☐ No	
During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No			
General Health Status, please rate your health. ☐ Excellent ☐ Good ☐ Fair ☐ Poor			

Please list any known allergies (including medications, latex, etc.) below:

Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.						
Name	Dosage	Frequency	Please indicate route			
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other

Surgery / Hospitalization, please include date and reason.	

Are you currently experiencing any of the following?			
Nausea or Vomiting	☐ Yes ☐ No	Chest Pains (Angina)	☐ Yes ☐ No
Productive/chronic cough	☐ Yes ☐ No	Pain wakes me at night	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Recent fever, chills, sweats	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Difficulty sleeping	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Visual problems	☐ Yes ☐ No	Heart palpitations	☐ Yes ☐ No
Hearing loss/ringing in ears	☐ Yes ☐ No	Loss of appetite	☐ Yes ☐ No
Difficulty walking	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Unusual weakness	☐ Yes ☐ No	Fatigue or myalgia	☐ Yes ☐ No
Joint pain or swelling	☐ Yes ☐ No	Unexplained weight changes	☐ Yes ☐ No

Patient name: ____ Acct #: _________________________

Have you been diagnosed with any of the following?			
Allergies	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Hepatitis, if yes, Type:	☐ Yes ☐ No	Kidney Disease/Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Respiratory problems	☐ Yes ☐ No
Auto Immune Disease If yes, Type:	☐ Yes ☐ No	Metal Implants	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Vision problems	☐ Yes ☐ No
Bowel or Bladder Disorder	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Cancer, If yes, Site:	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Cardiac Conditions	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No	Peripheral Vascular Disease	☐ Yes ☐ No
Currently Pregnant	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Speech problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Spinal Cord Stimulator	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Stomach Ulcers	☐ Yes ☐ No
Fractures	☐ Yes ☐ No	Stroke/TIA	☐ Yes ☐ No
Gall Bladder problems	☐ Yes ☐ No	Thyroid	☐ Yes ☐ No
Hearing loss	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No

Social History / Wellness	
Do you drink alcoholic beverages? ☐ Yes ☐ No	Do you use tobacco? ☐ Yes ☐ No
How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? ☐ At least 3 times per week ☐ 1-2 times per week ☐ Seldom or Never	

Current Condition
When did this problem(s) first begin?
Describe the problem(s).
Explain how problem(s) occurred.
Have you ever had this problem before? ☐ Yes ☐ No If yes, how many times?
Are your symptoms worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Same all day
How are you taking care of the problem(s) now?
My pain/problem is slowing getting: ☐ Worse ☐ Better ☐ Staying the same
My symptoms bother me: ☐ Constantly (100%) ☐ Most of the time (75%) ☐ Occasionally (50%) ☐ Once in a while (25%)
Do you have any numbness, tingling, or burning? ☐ Yes ☐ No If yes, please check one: ☐ Constantly ☐ Intermittently

Patient name: ____ Acct #: _____________________________

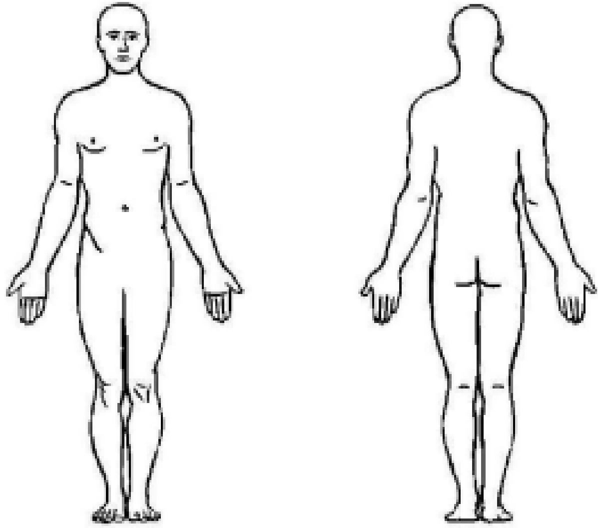
What functions could you perform before, that you now are unable to do?
Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.
Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.
Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No If yes, please tell us what it is:
What are your goals for therapy?

Symptom Rating

Mark location of symptom(s)

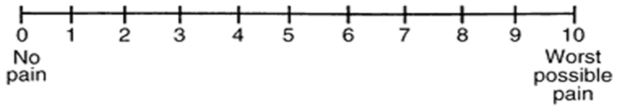
O for pain

X for numbness/tingling/burning



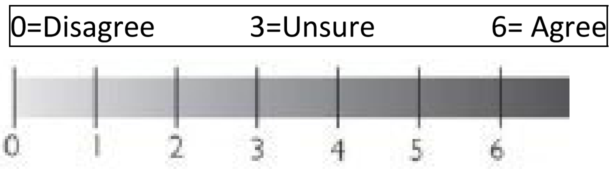
Please rate your pain - on a scale from 0 – 10
(0 = No Pain; 10 = Worst pain imaginable)

Current:	Best:	Worst:



"I should not do physical activity which (might) make my pain worse". Please rate your level of agreement on the scale below:

0=Disagree	3=Unsure	6= Agree



To the best of my knowledge the above information is accurate and complete.

Patient/Guardian signature ____ Date _______________________

Therapist signature ____ Date _____________________________