Rehab 4 Life Physical & Occupational Therapy Patient Registration Information

Please complete the following information. Print clearly using a black pen. Thank you.

Today's Date: ___________________

Last Name: _______________________ First Name: _____________________ Middle Initial: _______

Preferred Name: ________________ Social Security Number: ______ - ______ - ______

Birthdate: ____ / ____ / ____ Age: ____ Gender: M F Marital Status: Single Married Divorced Widowed

Address: __________________________ City: ___________________ State: _____ Zip Code: ________

Home Phone: __________________ Cell: __________________ Work (alternate): _________________

Email: ___________________ @ _____________ . ________

Do you prefer appointment reminders via text or email? (circle one) Email Text cell phone carrier: _________

Employed? Y N If yes, name of Employer: _______________________

How Did You Hear About Rehab 4 Life? __________________ Referring Physician: _________________

Emergency Contact Name ______________________________ Phone ___________________

Relationship to Patient _________________________________

Worker's Compensation or Personal Injury/Auto Injury Case, Please Complete the Following Information:

Claim Number: ________________________________ Date Claim Was Opened: ______________

Claim Contact Person: ___________________________ Phone: ____________________

Automobile Insurance Company: ____

Automobile Insurance Address: _____________________________ City: _________________ State: _____

Automobile Insurance ID #: _________________________________

Please have proof of both primary and secondary insurance available

Primary Insurance Information:

Insurance Company_________________________

Group #___________________________________

ID #______________________________________

Contact #__________________________________

Secondary Insurance Information:

Insurance Company_________________________

Group #___________________________________

ID #______________________________________

Contact #__________________________________

Rehab4LIFE
PHYSICAL & OCCUPATIONAL THERAPY

Getting you back to Work, Sport, Health, Life

History of Present Condition

Patient Name: ______________________ Occupation: _____________________________________

On a scale from 0-10, 0 being no pain, 10 being absolute worst pain, please rate your pain today:

0 1 2 3 4 5 6 7 8 9 10

Reason for Visit? __________________________ Personal Goals for Therapy: ________________________

When did symptoms begin? ____

(list specific date if possible)

Was the onset/timing of this episode: ☐ Gradual ☐ Sudden Any previous episodes? Y N

Which of the following best describes how injury occurred? (if condition is post-surgical, please indicate as per original injury)

☐ Unknown ☐ While Lifting ☐ Vehicle Accident ☐ A Fall

☐ Trauma ☐ Work Incident ☐ Dental Appointment ☐ Sports

☐ Degenerative Process ☐ Other (Please Specify) ___________________________________

Have you seen a physician? Y N Who? ______________________________ When?__________________

Have you had any tests performed? Y N Type of test(s) performed? ______________________________

Have you had any X-Ray's taken? Y N Results: ____

Are you currently on any medication? Y N (please list)____

Have you had any form of treatment prior to today's visit? Y N What Kind? _________________________

Since the onset, are your symptoms ☐ Improving ☐ Staying the Same ☐ Worsening

What aggravates your symptoms? (Check all that apply)

☐ Sitting ☐ Going to/Rising From Sitting ☐ Walking ☐ Up/Down Stairs ☐ Standing ☐ Squatting

☐ Lying Down ☐ Sleeping ☐ Looking Up Overhead ☐ Sustained Bending ☐ Reaching Overhead

☐ Reaching in Front of Body ☐ Reaching Behind Back ☐ Reaching Across Body ☐ Coughing/Sneezing

☐ Taking a Deep Breath ☐ Talking ☐ Chewing ☐ Yawning ☐ Swallowing ☐ Stress

☐ Repetitive Activity ____

☐ Household Activity ____

☐ Recreation/Sports Including: ____

What relieves your symptoms? (Check all that apply)

☐ Nothing ☐ Medication ☐ Wearing Splint/Orthosis ☐ Rest ☐ Cold ☐ Heat ☐ Sitting ☐ Standing

☐ Walking ☐ Lying Down ☐ Stretching ☐ Exercise ☐ Massage

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PHYSICAL & OCCUPATIONAL THERAPY

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Medical History

Patient Name: ______________________

Have you had any falls in the past year? Y N If yes, how many times? _______ ☐ Injured ☐ Uninjured

Are you currently pregnant or trying to get pregnant? Y N

Have you had any of the following? Explain

			Explain
Stroke	☐ Present	☐ Past	________________________
Heart Disease or Murmur	☐ Present	☐ Past	________________________
High Blood Pressure	☐ Present	☐ Past	________________________
Asthma	☐ Present	☐ Past	________________________
Diabetes	☐ Present	☐ Past	________________________
Epilepsy/Fainting	☐ Present	☐ Past	________________________
Impairment of Vision	☐ Present	☐ Past	________________________
Impairment of Hearing	☐ Present	☐ Past	________________________
Cancer	☐ Present	☐ Past	________________________
Drug Allergies	☐ Present	☐ Past	________________________
Osteoporosis	☐ Present	☐ Past	________________________

Do you smoke tobacco products? ☐ Present ☐ Past How much per day? ________________________

Have you ever sprained, strained, dislocated or fractured the following?

Head/neck (including concussion) ____________________________________Date________________

Trunk (ribs, vertebrae, sternum) ______________________________________Date________________

Low Back (vertebrae, discs, nerves) ___________________________________Date________________

Upper Extremity (shoulder, elbow, wrist, arm) __________________________Date________________

Lower Extremity (hip, leg, knee, ankle, foot) ____________________________Date________________

Please list any surgeries that you have had including the date of surgery:

____

____

Have you had Physical Therapy in the past? ☐ Yes ☐ No If yes, Where? ________________________

What condition were you being treated for? ____

I certify the above information is accurate and correct to the best of my knowledge. I will notify Rehab 4 Life immediately should any of this information change.

Patient Signature: ______________________________________ Date: ____________________

Print Name: ______________________________________

Rehab 4 LIFE

PHYSICAL & OCCUPATIONAL THERAPY

Consent to Treatment & Services

I, _________________________, herby consent and authorize Rehab 4 Life/At Home Therapy Services, its professional providers & associates to perform an evaluation and provide any necessary treatments to me as explained and agreed upon. I understand that I will be explained the purpose of all therapy procedures and treatments prior to receiving the procedure/treatment and that I may refuse any therapy procedure or treatment at any time. A representative of Rehab 4 Life/At Home Therapy Services has explained my plan of care to me and all of my questions have been answered and explained to me satisfactorily. I hereby authorize Rehab 4 Life/At Home Therapy Services to scan or photograph any medical information, current insurance card(s) and valid photo ID for electronic medical record purposes.

Patient/Guardian Signature: ______________________________ Date: _______________

Financial Responsibility Policy

I hereby agree to pay all copays and self-pay procedures/treatments AS SERVICES ARE PROVIDED. I understand that all deductibles and coinsurance will be billed to me as response is received from insurance company. I will promptly pay any amount due and owing upon receipt of the statement. If I am unable to pay balance in full, I understand I have 10 days from receipt of statement to contact Rehab 4 Life/At Home Therapy Services to make other payment arrangements. **I understand that failure of payment in full within 30 days of receipt of statement, will result in 1.5% interest accrual on any outstanding balance due and owing to Rehab 4 Life/At Home Therapy Services, which will accrue each month until balance is paid in full.**

I hereby authorize Rehab 4 Life/At Home Therapy Services to bill my insurance for services provided. I also hereby assign all payments of authorized benefits be made on my behalf to Rehab 4 Life/At Home Therapy Services. I understand that if my insurance benefits and/or eligibility DO NOT COVER OR APPROVE PAYMENT FOR SERVICES PROVIDED BY REHAB 4 LIFE/AT HOME THERAPY SERVICES, THAT I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY FOR ALL CHARGES RELATED TO SERVICES PROVIDED.

Patient/Guardian Signature: _______________________________ Date: _______________

Authorized Designated Individuals

Please list any individuals you would like to have access to your private health information and financial balances. If you prefer not to designate an authorized individual, please write “none” and sign.

Name	Relationship
Name	Relationship
Name	Relationship

I hereby authorize these designated parties to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of the designated parties must be verified before release of any information.

Patient/Guardian Signature: _________________________________ Date: ________________