

Patient Name:

Account #:

Case:

Location:

IE Date:



# PATIENT REGISTRATION FORM

PATIENT INFORMATION	Last Name		First	MI	Birth Date	Cell Phone#
	Address		Apt#	City	State	Zip
	SSN - Last 4 <small>(Legal Guardian's if under 18):</small>		Employer Name :		Employer # :	Marital Status
	E-Mail		Home Phone#		Primary Care Physician	Phone#
	Sex Listed On Insurance:      Male                                      Female					
INSURANCE	Emergency Contact		Relationship		Cell Phone#	
INSURANCE	<b>Primary Insurance</b>			<b>Claims Mailing Address (Listed on back of card)</b>		
	Policy#		Group#		Effective Date	
	Policy Holder Name		DOB		Relationship to Patient	
	Cell Phone Disclaimer: If you have included a Cell Phone number, you are giving our office or agent permission to call that phone.					
	<b>Secondary Insurance</b>			<b>Claims Mailing Address (Listed on back of card)</b>		
	Policy#		Group#		Effective Date	
	Policy Holder Name		DOB		Relationship to Patient	
OTHER INSURANCE	Do you have work/auto claim information? ( ) Y ( ) N		Date of injury		Claim#	
	If Yes - circle one:      Work      Auto					
	Insurance Name & Claims Mailing Address					
	Attorney/Adjuster Name		Attorney/Adjuster Phone#			

## UNIFORM OF ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL DISCLOSURE:

All information provided herein is true and correct. I give permission to HealthQuest Physical Therapy to release/obtain information, verbal and written, contained in my medical record, and other related information to/from my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related person, as needed. I authorize direct payment to HealthQuest Physical Therapy for services provided. I acknowledge that I am responsible for all account totals and balances. I promise to notify HealthQuest Physical Therapy if at any time there is a change in my Insurance Policy(s) or Benefits. I expressly guarantee payment of the account/dependent named above, and agree to pay any charges left unpaid in whole or in part by the insurance company. **Cash Based Physical Therapy Packages & Sessions sales are final and no refunds will be issued.** I understand packages do not expire, and can only be redeemed at the original location of purchase and that any unused sessions are transferable to family/friends at the original location of purchase **only**. I certify all information given is accurate. I certify that I have read and fully understand the above consents. **If the patient is a minor, their Legal Guardian must sign below.**

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Acct #: \_\_\_\_\_ Case#: \_\_\_\_\_ Date: \_\_\_\_\_

By taking the time to complete this form, you will be assisting us in planning your physical therapy treatment. Please be as thorough as possible. If there is information relevant to your treatment not outlined below, please bring it to the attention of your physical therapist. Your cooperation is greatly appreciated.

## Current Condition(s)/Chief Complaint(s)

Reason for referral to physical therapy: \_\_\_\_\_

Date of injury or onset of the problem: \_\_\_\_\_

Location of pain: \_\_\_\_\_

Is your current pain: Intermittent ☐ Constant ☐

Do you have any of the following symptoms: Numbness ☐ Tingling

## Have you experienced any of the following?

Changes in bowel or bladder function ☐

Unexplained significant lower or upper limb weakness ☐

Non-healing sores or wounds ☐

Pain that is worsened at night or not relieved by any position

Pain that is worse during rest vs. activity ☐

Unexplained weight loss ☐

Fatigue ☐

Referred or radiating pain ☐

Fever/Sweats ☐

Have you received physical therapy in the past 12 months? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, where and for what? \_\_\_\_\_

Please describe the treatment: \_\_\_\_\_

## Functional Status and Activity Level

Prior to the condition or injury, please rate your functional status with self-care and home management activities:

Excellent ☐ Good ☐ Fair ☐ Poor ☐

Please rate your current functional status with self-care and home management activities:

Excellent ☐ Good ☐ Fair ☐ Poor ☐

## Family/Social History

Do you live alone? \_\_\_\_\_ Yes \_\_\_\_\_ No If No, with whom do you live? \_\_\_\_\_

Are you currently working? \_\_\_\_\_ Yes \_\_\_\_\_ No What is your occupation? \_\_\_\_\_

Pertinent Family History \_\_\_\_\_

## Living Environment

In which type of home do you live? ☐ 1-story home ☐ 2-story home ☐ Apartment ☐ Tri-level ☐ Other: \_\_\_\_\_

Are there stairs in the home or in order to get into the home? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, number of steps: \_\_\_\_\_ Hand Railing present on: ☐ Right side ☐ Left side ☐ Both sides ☐ No hand railing

## General Health Status

Height \_\_\_\_\_ Weight: \_\_\_\_\_

What type of exercise or activity did you participate in prior to this condition? \_\_\_\_\_

How often did you participate in this activity or form of exercise? ☐ 5-7 times per week ☐ 3-5 times per week  
☐ 1-2 times per week ☐ 1-2 times every other week ☐ Once per month ☐ Other Please Specify: \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes: less than 1 pack per day ☐ or more than 1 pack per day

How often do you drink alcohol? \_\_\_\_\_ Zero \_\_\_\_\_ Less than 1 day \_\_\_\_\_ 1-2 days \_\_\_\_\_ 3-4 days \_\_\_\_\_ 5-7 days \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No Physician: \_\_\_\_\_

Patient Name \_\_\_\_\_ Account # \_\_\_\_\_ Case: \_\_\_\_\_

**Medical/Surgical History**

Have you ever been diagnosed as having any of the following conditions? (Please check yes or no in box)

	YES	NO	PT Comments		YES	NO	PT Comments
Osteoporosis				Have a Pacemaker			
Cancer				Hearing or Visual Impairment			
Diabetes				Thyroid Problem			
Arthritis				Kidney Disease			
High Blood Pressure				Vertigo			
Circulatory Problems				History of Falls			
Depression				High Cholesterol			
Seizures				Contagious Diseases			
Heart Problems				Stroke			

Please list any other injuries or diagnoses if not indicated above: \_\_\_\_\_

Have you ever had surgery? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list what type and the date(s)? \_\_\_\_\_

What activities has your doctor instructed you to limit or avoid? \_\_\_\_\_

**Medications**

Are you currently taking any over-the-counter medications, vitamins, or herbal supplements? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list which ones: \_\_\_\_\_

Have you had a flu shot recently? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, when: \_\_\_\_\_

Are you currently taking any of the following Medications (please check box and indicate name):

Corticosteroids		Name:	Antibiotics		Name:
Pain Relievers		Name:	Birth Control Pills		Name:
Insulin		Name:	Muscle Relaxers		Name:
Seizure Medication		Name:	Diuretics		Name:
Aspirin		Name:	Tylenol/Acetaminophen		Name:
Anti-Inflammatory		Name:	Heart Medications		Name:
Decongestants		Name:	Antidepressant		Name:
Sleep-Inducing drugs		Name:	Thyroid Medication		Name:

**Other Clinical Tests**

Have you had any of the following performed since your injury:

X Rays: ☐ MRI: ☐ Bone Scan: ☐ CAT scan: ☐ Comments: \_\_\_\_\_

Please list your current physicians: \_\_\_\_\_

Do you have an upcoming Doctor's Appointment and if so, what is the date? \_\_\_\_\_

What is your main goal in coming to physical therapy? \_\_\_\_\_

Who can we speak with regarding your treatment and billing?

\_\_\_\_\_ Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**Consent For Care And Treatment & Acknowledgment of Receipt of Notice of Privacy Practices**

I give consent for HealthQuest Physical Therapy to furnish medical care and treatment considered necessary and proper in treating my physical condition. The undersigned Patient/Guardian acknowledges he/she has been personally advised that copies of HealthQuest's Notice of Privacy Policies are posted at the point of care and that copies are available upon request.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## REFERRAL TRACKING FORM

**HealthQuest**  
PHYSICAL THERAPY

Account#:

Case #:

Location:

IE Date:

Patient Name

Doctor First Name

Doctor Last Name

Credentials  
(MD/DO)

City of Doctor's Office



Did your doctor or doctor's staff mention or refer you directly to HealthQuest?

YES ☐NO ☐

#1 Have you been a patient at HealthQuest in the past?

☐ YES☐ NO

#2 What lead you to HealthQuest (check all that apply)?

☐

Doctor/Staff Referral

☐

Family/Friend Recommended

☐

School Athletic Trainer

☐

HQ Receptionist Convinced me

☐

Event/Expo

☐

Employee Referral

HQ location employee works at

☐

Internet/Website

☐

Newspaper

☐

Outside Sign

☐

TV

☐

Other

If someone referred you to us, please provide the following information so we can thank them!

Name

Email Address

#3 If you checked more than one box in #2 above, what is the main (one) reason you chose HealthQuest?

## FOR OFFICE USE ONLY

Marketing Referral Category entered into Raintree?

☐ YESDate of next  
Doctor visit☐ Yet to  
provide☐ N/A

Reviewed With Patient

(PT INITIALS)

HQPT RX

☐ YES☐ NO

Doctor/Staff Direct Referral

☐ YES☐ NO

(Verify accuracy of ★ question above)

Primary Referral Source

Confirm #3 above

(TO BE COMPLETED BY CD ONLY)

(CD INITIALS)

Gift Card

☐ YES☐ NO