

HealthQuest PHYSICAL THERAPY 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					
	Emergency Contact		Relationship		Cell Phone#				
	Primary Insurance			Claims Mailing Address (Listed on back of card)					
	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.									
Secondary Insurance			Claims Mailing Address (Listed on back of card)						
Policy#			Group#			Effective Date			
Policy Holder Name			DOB			Relationship to Patient			
Do you have work/auto claim information? <input type="checkbox"/> Y <input type="checkbox"/> 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: _____

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



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

Internet/Website

Family/Friend Recommended

Newspaper

School Athletic Trainer

Outside Sign

HQ Receptionist Convinced me

TV

Event/Expo

Other

Employee Referral

HQ location employee works at

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?

YES

Date of next
Doctor visit

Yet to
provide N/A

Reviewed With Patient

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)

YES

NO