**Patient Registration Form - Workers Comp/MVA**

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| Patient Name: Preferred:  |
| Address, City, State, Zip: |
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| DOB: Social Security #: Email Address: |

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| Home Phone: | Appointment Reminder Method |
| Cell Phone: | □ Home Phone □ Cell Phone |
| Work Phone: | □ Work Phone |

Please keep in mind that communication via email over the internet is not a secure form of communication. By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

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| Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Partner's Name: |
| Financial Responsibility: ☐ Self ☐ Other, Please List: |
| 2nd Contact Name/Address: |
| 2nd Contact Phone: Relation:  |
| General Physician: Referred By: |
| Have you had Physical Therapy treatment since January of this year? ☐ Yes ☐ No If yes, # of Visits: |
| Have you had Chiropractic treatment since January of this year? ☐ Yes ☐ No If yes, # of Visits: |
| Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ NoIf yes, Home Healthcare Provider: |

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| **Accident Information**  |
|  □ MVA or □ WC  |  Date of Accident: |  State Accident Ocurred: |
|  Attorney’s Name:  |  Phone #: |
| **Case Information**  |
| Name of Employer/Insured: |  Phone #: |
| Address: |
| Claim or Case #: |
| Nurse Case Manager Name: |  Phone #: |
| Adjustor Name: |  Phone #: |

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| **Consent to Treat/Assignment of Benefits/Acknowledgements** |
| I hereby authorize and consent to treatment/services for myself, or on the behalf of the above-named patient performed by the staff at Physical Therapy Care of Fort Bend and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.I assign payment for these services directly to Physical Therapy Care of Fort Bend. I authorize the filing of claims to my insurance plan and authorize Physical Therapy Care of Fort Bend to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believed were covered services, resulting in my responsibility for paying for these services.I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Patient/Guardian Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name and Relationship to the Patient |

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| **Financial Policy** |
| **Name:** |
| **Cancellation/No Show**Successful therapy is dependent on a strong working relationship between the patient and the therapist. Maximum progress and success are made when the patient is an active participant in their home exercise program and attends all appointments.Physical Therapy Care of Fort Bend requires a 24-hour notice for ALL cancellations. There may be a fee assessed which is not covered by insurance and would be an out-of-pocket expense for cancellations without proper notice.If a cancellation is unavoidable, we do ask that you give us as much notice as possible so we may offer that appointment time to another patient. * If you arrive later than 15 minutes after your scheduled appointment time, we may ask you to reschedule.
* After more than one cancellation or no show, we require that you call the day of for an appointment.
* 2 “no show” appointments may result in discharge from therapy.

**Payment for services is due at the time services are rendered** We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.Patient/Guardian Signature: Date: |

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| **Photo/Video Release** |
| I grant to Physical Therapy Care of Fort Bend and its affiliated entities, and its representatives and employees (collectively the “Physical Therapy Care of Fort Bend”) the right to take photographs and/or videos of me in connection with my participation in physical therapy services. I authorize the Physical Therapy Care of Fort Bend, to copyright, use and publish the same in print and/or electronically. I agree that the Physical Therapy Care of Fort Bend may use such photographs and/or videos of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content and waive any right to compensation, therefore I understand that I may revoke this authorization but only in writing delivered to the clinic Office Manager. I understand that if I choose to revoke this authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this authorization. (Please check a box below)□ Agree □ DeclinePatient/Guardian Signature: Date: |



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| **PATIENT HEALTH QUESTIONNAIRE** |
| **Patient Name: Preferred Name:** |
| 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. |
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| **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 |

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| **Surgery / Hospitalization, Please Include Date and Reason.** |
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| **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 |

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| **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 |

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| **Have you been diagnosed with any of the following?** |
| Allergies | * Yes ☐ No
 | High Blood Pressure | * Yes ☐ No
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| Anemia | * Yes ☐ No
 | HIV | * Yes ☐ No
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| Hepatitis, If Yes, Type: | * Yes ☐ No
 | Tuberculosis | * Yes ☐ No
 |
| Respiratory Problems | * Yes ☐ No
 | Kidney Disease/Problems | * Yes ☐ No
 |
| Auto Immune DiseaseIf yes, Type: | * Yes ☐ No
 | Spinal Cord Stimulator | * 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
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| Currently Pregnant | * Yes ☐ No
 | Seizures | * Yes ☐ No
 |
| Depression | * Yes ☐ No
 | Speech Problems | * Yes ☐ No
 |
| Diabetes | * Yes ☐ No
 | Hearing Loss | * Yes ☐ No
 |
| Stroke/TIA | * Yes ☐ No
 | Fractures | * Yes ☐ No
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| **Current Condition** |
| When did this problem(s) first begin? |
| Describe the problem(s). |
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| Explain how problem(s) occurred. |
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| 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 |
| What functions could you perform before, that you now are unable to do? |
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| Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc. |
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| Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results. |
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| Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ NoIf yes, please tell us what it is:  |
| What are your goals for therapy? |

**I will advise the therapist if there is any change in my physical condition which will alter my response to any of the question on this form.**

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