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 (Legal Guardian's if under 18):	Employer Name :	Employer # :	Marital Status	
E-Mail	Home Phone#	Primary Care Physician	Phone#	
Sex Assigned at Birth:	Male	Female		
Emergency Contact	Relationship	Cell Phone#		

INSURANCE

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

OTHER INSURANCE

Do you have work/auto **claim** information? ( ) Y ( ) N If Yes - circle one: Work Auto	Date of injury	Claim#
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 ☐
Non-healing sores or wounds ☐
Pain that is worse during rest vs. activity ☐
Fatigue ☐
Fever/Sweats ☐
Unexplained significant lower or upper limb weakness ☐
Pain that is worsened at night or not relieved by any position ☐
Unexplained weight loss ☐
Referred or radiating pain ☐

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 ☐5-7days

Are you pregnant? ____ Yes _____ No **Physician:** ____

Patient Name: ________________________ Acct #: _____________ Case#: _____________ Location:

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? ____

Do you have a follow up appointment scheduled with your doctor? Yes No Date: Date unknown:

Have you had a flu shot recently? _____Yes ____No If yes, when:

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: ____

____

____

Who can we speak with regarding your treatment and billing?

Contact Name **Phone Number**

Current Medication List: See Medication List Provided

Medication	Dose	Frequency

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
- ☐ 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? ☐ YES

Date 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 INITALS)

Gift Card ☐ YES ☐ NO

R10/5/21