ProRehab

Patient Registration Form

Name:	Preferred:
Address, City, State, Zip:	
DOB:	Social security #:
Email Address:	

Home Phone:	Appointment Reminder Method
Cell Phone:	☐ Home Phone ☐ Cell Phone ☐ Work Phone
Work Phone:	☐ Text Message Reminder ☐ Voice Call Reminder

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.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Partner's name:
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 # of visits:
Have you had Chiropractic treatment since January of this year? ☐ Yes ☐ No # of visits:
Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ No If yes, Home Healthcare Provider:

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information.

Financial Responsibility: ☐ Self ☐ Other, please list:

Primary Insurance:	Secondary Insurance:
Policy #	Policy #
Group #	Group #
Insured Name:	Insured Name:
Insured DOB:	Insured DOB:

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 ProRehab 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 ProRehab. I authorize the filing of claims to my insurance plan and authorize ProRehab 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

PATIENT HEALTH QUESTIONNAIRE

Patient Name: **Name You Go By:**

What are your pronouns? ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other:

Do you think of yourself as: ☐ Male ☐ Female ☐ Transgender
☐ Neither exclusively male nor female ☐ Additional gender category, please specify: ☐ Decline to Answer

What sex was originally listed on your birth certificate? ☐ Male ☐ Female ☐ Decline to Answer
For billing purposes, it is helpful to know gender assigned at birth. There can be confusion when a patient legally changes their birth certificate to the gender they align with, but insurance companies' data is lagging behind.

Occupation: Height: Weight:

Are you? ☐ Right-handed ☐ Left-handed Leisure Activities/Hobbies:

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.

Current Condition

When did this problem(s) first begin/date of onset?
If chronic, when did you seek medical treatment?

Is your current condition related to recent surgery? ☐ Yes ☐ No If yes, specify date of surgery:

Describe the problem(s).

Explain how problem(s) occurred.

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?

Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.

Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.

Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No
If yes, please tell us what it is:

What are your goals for therapy?

Surgery / Hospitalization, please include date and reason.	

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

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	

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

Have you been diagnosed with any of the following?			
Allergies	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Hepatitis, If Yes, Type:	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Respiratory Problems	☐ Yes ☐ No	Kidney Disease/Problems	☐ Yes ☐ No
Auto Immune Disease If 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
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

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

Signature: _____ Date: _____

Clinician Signature: _____ Date _____