PRO SPORTS PERFORMANCE
PHYSICAL THERAPY

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name: _____ First Name: _____
Address: _____ City/State: _____ Zip: _____
Date of Birth _____/_____/_____ Sex: M F Marital Status: S M D W SEP
Social Security #: _____-_____-_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____
E-Mail Address: _____

Emergency Contact: _____ Phone Number: (_____)_____-_____

POLICY HOLDER'S EMPLOYMENT:

Employer: _____
Address: _____ City/State: _____ Zip: _____
Business Phone Number: (_____)_____-_____

PRIMARY INSURANCE:

Insurance Company: _____
Policy Number: _____ Group Number: _____
Insurance Address: _____
Policy Holder: _____ **Policy Holder SSN:** _____
Policy Holder Address: _____ **Policy Holder Employer:** _____
Policy Holder Date of Birth: _____/_____/_____ **Relationship to Insured:** _____

SECONDARY INSURANCE:

Insurance Company: _____
Policy Number: _____ Group Number: _____
Insurance Address: _____
Policy Holder: _____ **Policy Holder SSN:** _____
Policy Holder Address: _____ **Policy Holder Employer:** _____
Policy Holder Date of Birth: _____/_____/_____ **Relationship to Insured:** _____

Is this Visit covered by Worker's Comp? _____ No Fault? _____
Date of Accident:_____/____/_____ (WC) Employers Name:_____
(WC)Employer Address_____
Employer Phone Number: _(_____)_____ Insurance Carrier:_____
Insurance Carrier Address:_____
Claims Adjuster:_____ Claims Adjuster Phone Number: _____
WCB #:_____ Carrier Case #: _____
Are you currently working?_____ If no, last date worked: _____
Attorney Name:_____ Phone Number: _____

Have you had Physical Therapy before?_____ If yes, please provide date last treated: _____
How did you first learn about Pro Sports Performance Physical Therapy_____

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CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Pro Sports Performance Physical Therapy, PC to furnish medical care and treatment to _____considered necessary and proper in diagnosis or treating his/her physical and mental condition.

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION FOR RELEASE OF INFORMATION BY PRO SPORTS PERFORMANCE PHYSICAL THERAPY, PC

I hereby authorize and direct the above named clinical practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such treatment. Upon my request for release of my medical records, I hereby authorize Pro Sports Performance Physical Therapy, PC to furnish all records and results to the parties I specify.

SIGNATURE: _____ **DATE:** _____

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical costs of the care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

SIGNATURE: _____ **DATE:** _____

NOTICE OF PRIVACY PRACTICES

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices On this date _____ _____ I received and reviewed Pro Sports Performance Physical Therapy PC, Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information. I had an opportunity to raise questions regarding this policy and all of my questions have been answered. This authorization will remain effective until such time as I notify Pro Sports Performance Physical Therapy PC in writing, by certified mail, of requested changes.

SIGNATURE: _____ **DATE:** _____

PATIENT MEDICAL HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Name: _____ Date of Birth: _____

Family Physician: _____

Referring Physician: _____ Date of last General Health Check-up: _____/_____/_____

Date of First Doctor Visit for this Injury: _____/_____/_____

Occupation: _____ Did you miss work because of injury? YES NO

Last Date Worked Due to this Injury: _____/_____/_____ Date Returned to Work After Injury: _____/_____/_____

Is an Attorney Involved in this Case? YES NO

Have you had Surgery for this injury? YES NO

Type of Surgery / Date: _____ Took Place at: _____

Pain (please draw a vertical line where you would rate your pain intensity): 0----------5----------10

No Pain Maximum Pain

My pain can be described as (please circle all that apply):

Constant Intermittent Sharp Dull Aching Stabbing Numbness Pins/Needles

Are You Currently Taking Any Prescription or Non-Prescription Medications? YES NO

Anti-Inflammatory ____ Muscle Relaxers ____ Pain Medication _____

List Medications: _____

Are You Allergic to any Medications? YES NO List Medications: _____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

	YES	NO		YES	NO
Chiropractor	___	___	X-Rays	___	___
General Practitioner	___	___	MRI	___	___
Massage Therapy	___	___	CT-Scan	___	___
Neurologist	___	___	EMG/NCV	___	___
Occupational Therapy	___	___	Myelogram	___	___
Physical Therapy	___	___	Emergency Room Care	___	___
Orthopedist	___	___	Podiatrist	___	___

Other: _____

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	___	___	Severe or Frequent Headaches	___	___
Shortness of Breath/Chest Pain	___	___	Vision or Hearing Difficulties	___	___
Coronary Heart Disease or Angina	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker?	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Bowel or Bladder Problems	___	___
Heart Attack or Surgery	___	___	Weakness	___	___
Stroke/TIA	___	___	Weight Loss/Energy Loss	___	___
Congestive Heart Disease	___	___	Hernia	___	___
Blood Clot/Emboli	___	___	Varicose Veins	___	___
Epilepsy/Seizures	___	___	Allergies	___	___
Thyroid Disease or Goiter	___	___	Any Pins or Metal Implants	___	___
Anemia	___	___	Joint Replacement Surgery	___	___
Infectious Diseases	___	___	Neck Injury/Surgery	___	___
Diabetes	___	___	Shoulder Injury/Surgery	___	___
Cancer or Chemotherapy/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Gout	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Are You Pregnant?	___	___
Latex Sensitivity/Allergy?	___	___	Do You Smoke?	___	___

List any other information that would assist us in your care: _____

_____

Patient/Guardian Signature: _____ Date: _____