First Health Physical Therapy **PATIENT REGISTRATION**

I. Personal Information

Name (Last, First) _____

Birthdate _____ Gender: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Other ☐

Address _____ Apt #_____ City _____ State _____ Zip _____

Phone Number _____ Cell _____ Email:_____

Emergency Contact _____ Relationship _____

Home Phone _____ Work Phone _____ Extension _____

Referred By _____

II. Insurance and Payment

Insurance Company _____ Insurance ID Number_____ Policy Holder _____

Fee $_____/ per visit Insurance will cover _____ % Patient responsibility _____

Deductible per year $ _____ $ _____ has been met Out of pocket $ _____ $ _____ has been met

III. Practice Policy & Patient Signature

Cancellations: *Your appointment time is exclusively for you. It is for this reason that we request you give us* ***a minimum*** *of* ***24 hours notice*** *when canceling or you will be charged for the appointment.* ***The cancellation fee is*** ***$50.00.***

Confidentiality: NOTICE OF PRIVACY AND PRACTICES As required by the Privacy Regulations of the Health Insurance Portability and Accountability Act (HIPAA) EFFECTIVE DATE: APRIL 14, 2003

This office adheres to all rules regarding the confidentiality of patient records. Employees have access only to patient information necessary to properly perform the function of their jobs. This office will communicate with the patient's insurance companies and other health care practitioner(s) by letter, phone, or fax upon written permission from the patient. Only information necessary to process claims is released to insurance companies.

Patient Acknowledgement and Consent:

1. I have been informed of the regulations regarding the Patient Health Information Notice of Privacy and Practices by First Health Physical Therapy.
2. I further authorize First Health Physical Therapy to release to the appropriate agencies, any information acquired in the course of my, or the above named patient's, examination and treatment.
3. If assignment is accepted, I authorize and request my insurance companies to pay directly to First Health Physical Therapy benefits otherwise payable to me. **I understand that accepting assignment is a courtesy extended to me by this office and that I am financially responsible for any coinsurance, deductibles, and services that are not covered or deemed "not medically necessary" by my insurance companies.** Further, I understand that if an insurance claims **if not paid within 45 days, I am responsible for the full amount immediately.**
4. If assignment is not accepted, I understand that I am financially responsible for all services and payment is due at each visit unless other arrangements have been made.
5. If First Health Physical Therapy is a participating provider with my insurance companies, I understand that I am subject to the terms and conditions of my insurance policy.
6. I have read and understand the cancellation policy.
7. I authorize the release of any medical information necessary to process all claims, and I authorize First Health Physical Therapy to communicate with my insurance companies and other health care practitioner(s) as necessary by letter, phone, or fax.
8. I hereby authorize First Health Physical Therapy through its appropriate personnel to perform, or have performed upon me, or the above named patient appropriate assessment and treatment procedures relating to the diagnosis stated by my referring physician.
9. I have read the above information regarding my insurance policy. I certify that the information above, to the best of my knowledge, is true and accurate. I authorize my insurance carrier to pay First Health Physical Therapy directly for services provided. I agree to pay First Health Physical Therapy the entire amount of bills incurred for physical therapy services provided not covered by my insurance carrier.

Signature _____ Date _____

FIRST HEALTH PHYSICAL THERAPY

Medical History Form

1. Please mark the appropriate boxes that apply to your medical history:

☐ Diabetes	☐ Hypertension	☐ Cancer	☐ Heart Disease	☐ Stroke
☐ Asthma	☐ Heart Attack	☐ Emphysema	☐ Tuberculosis	☐ Angina
☐ Hepatitis	☐ Osteoarthritis	☐ Pacemaker	☐ Epilepsy	☐ Pregnant
☐ Allergies	☐ Alcohol abuse	☐ Depression	☐ Tobacco Use	☐ Drug Abuse
☐ Cardiovascular Disease		☐ Rheumatoid Arthritis		

2. Please list any other diseases or conditions not mentioned:

3. Please list any previous surgeries:

4. Please list any medications you are currently taking and specify dosage:

5. What is your goal for therapy?

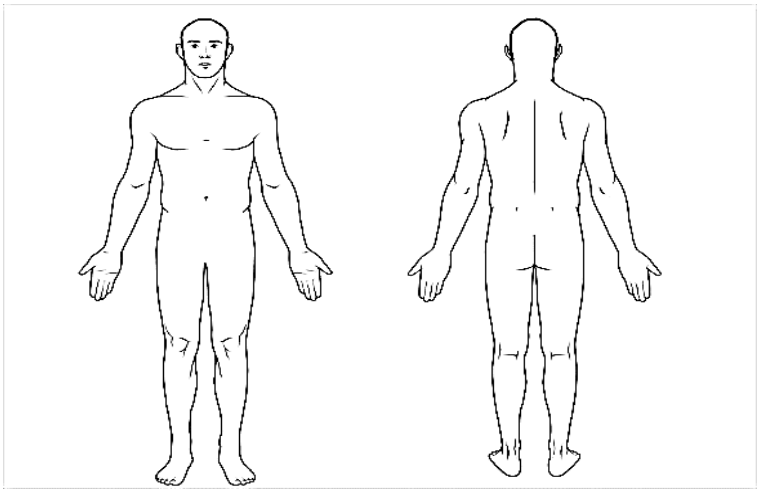
6. Please rate your pain at best: (0 = None) 0 1 2 3 4 5 6 7 8 9 10 (10 = Unbearable)

7. Please rate your pain at worst: (0 = None) 0 1 2 3 4 5 6 7 8 9 10 (10 = Unbearable)

8. Please circle the items that best describe your pain:

Sharp Shooting Radiating Twinge Dull/Ache Throbbing Numbness Tingling Burning

9. Please mark on the diagram where your pain is located:



10. Height ____ ft ____ in

11. Weight _____ lbs

12. Blood pressure: _____ systolic

_____ diastolic

SIGNATURE: _____

QuickDASH - Initial Patient name:_____ Date:_____

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD9 Code: