TOEPPERWEIN PHYSICAL THERAPY™ & Spine Rehab

Patient Registration Form

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB**:
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Address *(Street)*			**Social Security:** - -
(City, State, Zip)			**Referring Physician:**
Home Phone:	**Cell Phone:**		**Primary Care Physician:**
Employer:	**Occupation:**		**Work Phone:**
In case of emergency notify:	**Relation:**		**Phone:**

Yes ☐	**No ☐**	**Permission to leave Information with a family member or on an answering machine.**
Yes ☐	**No ☐**	**Permission to discuss treatment options with spouse, parent or legal guardian.**

INSURANCE INFORMATION

Primary Insurance:			
Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**	Insured's Name:		Policy ID:
	Insured's DOB:		Group #:
	Insured's Employer:		
Secondary Insurance:			
Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**	Insured's Name:		Policy ID:
	Insured's DOB:		Group #:
	Insured's Employer:		

FINANCIAL RESPONSIBILITY

Name:	**Phone:**	**Relationship to Patient:**
Address*: (Street)*		**Social Secutiry:**
(City, State, Zip)		**DOB**:

OUR POLICY ON BILLING AND INSURANCE FEES

As a courtesy Toepperwein Physical Therapy will verify your coverage and bill your insurance carrier on your behalf. Please be advised that the information your insurance company provides to us is only a quote of your benefits and not a guarantee of payment. Payment for all professional services rendered is the responsibility of the patient, parent, or guardian. I hereby authorize Toepperwein Physical Therapy and Spine Rehab, P.C. to provide any physical therapy services or related services as deemed necessary by the physical therapist(s).By signing below you are consenting for all insurance carriers, Medicare, and/or appropriate agencies to pay directly to Toepperwein Physical Therapy and Spine Rehab, P.C. I authorize Toepperwein Physical Therapy and Spine Rehab, P.C., to release information contained in my medical and financial records, including diagnosis and test results to my referring physician insurance company, worker's compensation adjuster, or an attorney's office if applicable.

Patient or Guardian Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

I understand that under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA),** I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been given the opportunity to review the **Toepperwein Physical Therapy Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my protected health information. I understand that Toepperwein Physical Therapy has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this office at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**. *NOTE: Uses and disclosures for treating physicians' office may be permitted without prior consent in an emergency.*

I understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time. If I do revoke my authorization it will become effective the following date of received written revocation, or withdrawal. I have read & fully understand the above general consent form. Any questions I have had have also been answered to my satisfaction. By signing this form I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive or not to receive my health information.

PROVIDER-PATIENT EMAIL / TEXT COMMUNICATION CONSENT FORM

PLEASE PICK **ONE** OF THE FOLLOWING AS YOUR PREFERRED METHOD OF REMINDER COMMUNICATION:

☐Phone:_____	☐ Text:_____	☐Email:_____

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS CONSENT FORM. I UNDERSTAND THE RISKS ASSOCIATED WITH THE COMMUNICATION OF EMAIL BETWEEN THE PROVIDER AND ME, AND CONSENT TO THE CONDITIONS OUTLINED HEREIN, AS WELL AS ANY OTHER INSTRUCTIONS THAT THE PROVIDER MAY IMPOSE TO COMMUNICATE WITH PATIENTS BY EMAIL/TEXT. I ACKNOWLEDGE THE PROVIDER'S RIGHT TO, UPON THE PROVISION OF WRITTEN NOTICE; WITHDRAW THE OPTION OF COMMUNICATING THROUGH EMAIL. ANY QUESTIONS I MAY HAVE HAD WERE ANSWERED

CONSENT TO THERAPY

Please check each line to verify you have read, understand, and agree to the following policies:

- ☐ I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.
- ☐ I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care is not an exact science, so no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.
- ☐ I understand that if I do not see my physical therapist for two weeks or miss three consecutive appointments, the physical therapist may discharge my case. Once I have been discharged, I understand that I will need a new physician's order/referral for any further therapy and will be receiving a new evaluation. This is in compliance with the Texas State Law.
- ☐ I am responsible for any services not covered by my insurance. I have read and fully understand our Policy on Billing and Insurance Fees.
- ☐ We may from time to time take photographs of patients during their course of care with us. We insure all photos protect your modesty and only show you at your best! Do you consent to having your photograph taken? ☐ Yes ☐ No
- ☐ I understand that Toepperwein Physical Therapy & Spine Rehab, P.C. is not responsible for valuable and personal property brought to the facility.
- ☐ No shows or cancellations made 24 hours or less before an appointment will be subject to a $45 fee.
- ☐ If after two same day cancellations have been made all future appointments will be removed and you will be asked to schedule on a first come/ first serve basis. We recognize legitimate reasons for missing appointments and keep accurate records of those occurrences, but we need your cooperation in contacting our office as soon as possible if you are unable to keep your scheduled appointments.
- ☐ If you are more than 15 minutes late, the therapist may determine that there is insufficient time to provide proper treatment, and you may be charged our cancellation fee.
- ☐ If at any time your insurance changes, you must inform us ASAP. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. Toepperwein Physical Therapy and Spine Rehab, P.C. does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

By signing below, You agree that you have received or been offered a copy of the Notice of Privacy Practices and agree with all the above policies.

Patient Name (Print):_____ Legal Guardian Name (Please print):_____

Patient or Legal Guardian (Signature):_____ ***Date***: _____

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INITIAL EVALUATION

Salutation:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.		**DOB:**	**Age:**
	Name *(Last, First, M.I.):* ☐ M ☐ F		**Height**:_____ **Weight**:_____	
Referring Physician	Doctor which referred you to our clinic:			
	When is your next doctor's appointment for follow-up of this condition?			
Current Symptom Onset	How recent did the symptoms start or become worse? _____ ☐ Days ☐ Weeks ☐ Months ☐Years ago			
	How did the symptoms appear? ☐ Suddenly ☐ Gradually ☐ Insidiously ☐ Injury			
	How long have the symptoms persisted for? _____ ☐ Days ☐ Weeks ☐ Months ☐Years			
	What was the cause of the symptoms? (i.e. car accident, fall, surgery, other)			
	Have the symptoms ☐ Worsened ☐ Improved ☐ Remained the same			
Problem	First Symptom ☐ Pain ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Other _____			
	First area affected by symptoms:	☐ Neck		☐ Wrist ☐ R ☐ L
		☐ Back	☐ upper ☐ mid ☐ low	☐ Hip ☐ R ☐ L
		☐ Shoulder	☐ R ☐ L	☐ Knee ☐ R ☐ L
		☐ Elbow	☐ R ☐ L	☐ Ankle ☐ M ☐ L
	What is the intensity of the pain? ☐ Mild ☐ Moderate ☐ Severe ☐ Unbearable			
	Do the symptoms radiate to another area? (please list)			
	Do the symptoms change after resting? ☐ Increase ☐ Decrease ☐ Remain the same			
	Do the symptoms change after activity? ☐ Increase ☐ Decrease ☐ Remain the same			

Medication	Medication Name:	How Much (dose):	How Often:
	☐ Provided a list of medications		

Current Pain	What would you rate your pain level NOW?	☐ No Pain ☐ 1 ☐ 2 ☐ 3 ☐4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Worst Pain
	What is your pain rated in the morning?	☐ No Pain ☐ 1 ☐ 2 ☐ 3 ☐4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Worst Pain
	What is your pain rated in the afternoon	☐ No Pain ☐ 1 ☐ 2 ☐ 3 ☐4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Worst Pain
	What is your pain rated in the evening?	☐ No Pain ☐ 1 ☐ 2 ☐ 3 ☐4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Worst Pain

Activities	List activities that AGGRAVATE symptoms:	List activities which EASE/DECREASE SYMPTOMS:
	1.	1.
	2.	2.
	3.	3.

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Work Activities	List any strenuous activities performed at work (lifting, bending, twisting, sitting/standing for long periods, repetitive motion activity)
	How often is this activity performed ☐ Frequently ☐ Regularly ☐ Occasionally ☐ Hourly ☐ Daily ☐ Constantly
	Are your symptoms aggravated by this activity? ☐ Yes ☐ No
Sitting/ Standing	How long can you remain sitting before having to change position? _____/_____ (Minutes / Hours)
	In what position(s) do you usually sit? ☐ Guarded ☐ Even weight distribution ☐ Uneven weight distribution
	How long can you remain standing before having to change position? _____/_____ (Minutes / Hours)
Work Activities	Do you experience discomfort while using stairs? ☐ Yes ☐ No If yes, is the discomfort ☐ Minimum ☐ Moderate ☐ Severe
	Do you use any assistive device(s) for movement? (walker, cane, wheelchair)

Please skip questions of Prior Symptoms if it does not apply to you.

Prior Symptoms	Prior Treatment, provider type, and name: (Dr., PT, DO, Chiropractor, RMT)
	Prior Treatment Types: ☐ Moist Heat ☐ Cold Pack ☐ Ultrasound ☐ Massage ☐ Interferential current ☐ Traction ☐ Other
	How long ago was the treatment received? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years ago
	How would you rate your recovery? ☐ Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐ Excellent
	How long ago was the treatment received? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years ago

Please list surgeries which may relate to the condition we will be treating.

Related Surgeries	Most Recent Surgery:	Date of surgery: _____/_____/_____
	Location of incision:	Incision has: ☐ Healed ☐ Not healed
	Physician:	Recovery was: ☐ Poor ☐ Satisfactory ☐ Full
	Other Surgery:	Date of surgery: _____/_____/_____
	Location of incision:	Incision has: ☐ Healed ☐ Not healed
	Other Surgery:	Date of surgery: _____/_____/_____
	Location of incision:	Incision has: ☐ Healed ☐ Not healed
Precautions	Have you been given any precautions or limitations by your doctor? ☐ Yes ☐ No	
	If yes, please explain:	

Please skip questions of Accident Information if it does not apply to you.

Accident	Date of your injury : _____/_____/_____	☐ Auto ☐ Work ☐ Other _____
	Describe how and what happened in your accident:	
	Did you receive treatment after your injury / accident? ☐ Yes ☐ No	Were you able to continue working? : ☐ Yes ☐ No
	What treatment(s) did you receive? (ER, X-Rays, Medication(s))	
	Did the treatment you received help your condition? : ☐ Yes ☐ No ☐ Somewhat	
	If not able to continue working, when are you to be re-evaluated by your physician for returning to work? _____/_____/_____	

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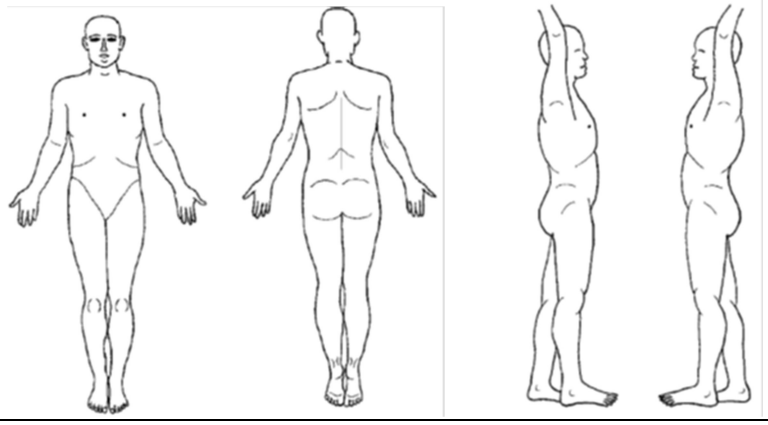
HEALTH HISTORY

Check if you or a family member have, or have had, any of the following symptoms:	
Cancer	☐ You ☐ Family Member
Diabetes	☐ You ☐ Family Member
High Blood Pressure	☐ You ☐ Family Member
Heart Disease	☐ You ☐ Family Member
Angina / Chest Pain	☐ You ☐ Family Member
Stroke	☐ You ☐ Family Member
Osteoporosis	☐ You ☐ Family Member
Osteoarthritis	☐ You ☐ Family Member
Rheumatoid Arthritis	☐ You ☐ Family Member

Please indicate each area(s) of your current pain or other symptoms



Check if You have, or have had, any of the following symptoms:		Check if You have, have had, or experienced in the past 3 months:	
Allergies / Asthma	☐ Yes ☐ No	A change in your health	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Loss of strength or energy	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Nausea / Vomiting	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	Fevers / Chills / Sweats	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Menstrual irregularities	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Hearing Impairment	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No
Vision Impairment	☐ Yes ☐ No	Upper Respiratory infection	☐ Yes ☐ No
Speech Impairment	☐ Yes ☐ No	Urinary tract infection	☐ Yes ☐ No
Sexually Transmitted Disease	☐ Yes ☐ No	Been bothered by feeling down	☐ Yes ☐ No
Positive Tuberculosis Testing	☐ Yes ☐ No	Depressed, or hopeless	☐ Yes ☐ No
Living with someone who has Tuberculosis	☐ Yes ☐ No	Change in bowel / bladder function	☐ Yes ☐ No

OTHER PROBLEMS

I Have Difficulty with:		Answer the following questions:	
Driving	☐ Yes ☐ No	Are your symptoms? ☐ Getting worse ☐ The Same ☐ Improving	
Lifting	☐ Yes ☐ No	How are you able to sleep at night? ☐ Fine ☐ Moderately difficulty ☐ Only with medication	
Walking	☐ Yes ☐ No	Are you Currently? ☐ Pregnant ☐ Under Stress	
Bending at the waist	☐ Yes ☐ No	Have you had any medical Tests performed recently? If yes state where the test(s) were performed	Date:
Running	☐ Yes ☐ No	X-Ray ☐ Yes ☐ No	
Playing Sports	☐ Yes ☐ No	EMG ☐ Yes ☐ No	
Standing	☐ Yes ☐ No	MRI ☐ Yes ☐ No	
Getting up from a chair	☐ Yes ☐ No	Cat Scan ☐ Yes ☐ No	
Regular exercise	☐ Yes ☐ No	Ultrasound ☐ Yes ☐ No	