



PATIENT REGISTRATION & CONSENT TO TREAT FORM

Last Name	First Name	MI	DOB	Sex	SSN
Address		City/State/Zip		Marital Status	
Home Phone #	Cell Phone #	E-mail Address			
Employer Name		Employer Phone		Current Position	
Employer Address	City/State/Zip				

IN CASE OF EMERGENCY

Contact's Full Name	Relationship to Patient	Cell Phone #	Other Phone
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(Optional) GUARANTOR

(Guarantor info required if patient is under 18; Please state the name, phone number and address of the person financially responsible for all balances relating to this patient.)

Guarantor Full Name	Address
City/State/Zip	Guarantor Phone # Relationship to Patient

CONSENT TO TREAT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO PROBILITY PHYSICAL THERAPY IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS.

A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF PROBILITY PHYSICAL THERAPY AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE. I CONSENT TO BEING KNOWINGLY PHOTOGRAPHED OR VIDEOTAPED BY AUTHORIZED PERSONNEL OF PROBILITY PHYSICAL THERAPY FOR MEDICAL REASONS WHEN NEEDED SUCH AS POSTURAL CORRECTION, GAIT/MOVEMENTANALYSIS OR EDUCATIONAL PURPOSES. FOR REFERENCE THE TRINITY HEALTH NON- DISCRIMINATION POLICY IS POSTED IN EACH CLINIC. A COPY OF THIS NON-DISCRIMINATION POLICY WILL BE PROVIDED UPON REQUEST.

After reviewing the corresponding policies, please initial next to each statement:

I acknowledge that I have read, understand and agree to the Notice of Patient Information Practices Probility may not sell or disclose protected health information to a business associate or any other third party for that party's own marketing purposes.

By signing this form, you authorize Probility to contact you regarding marketing of health-related products and services through email or postal mail.

If you wish to OPT OUT of such marketing materials, please check this box: []

I acknowledge that I have read, understand and agree to the Cancellation/No-Show Policy
I acknowledge that I have read, understand and agree to the Notice of Billing Department Policies

Authorized Signature (parent signature for minors)

Date

MRN: _____

STAFF USE ONLY



POST-CONCUSSION PATIENT QUESTIONNAIRE

Name: _____ Date: _____

1) Briefly explain your current symptoms: _____

2) How did your injury occur? _____

3) Date of onset / injury: _____

4) Loss of consciousness: Yes No

5) Nausea / Vomiting: Yes No

6) Memory Loss: Yes No

7) Headaches / Migraines: Yes No

8) Please describe any previous injuries, surgeries, or other problems / pain with any part of your body:

9) Are you experiencing any neck or other body pain?

How long does your pain last? _____

Please explain and rate on a scale of 0 -10 (0 = no pain, 5= moderate, 10 = worst ever)

- 0 1 2 3 4 5 6 7 8 9 10

10) Are you experiencing any dizziness? Yes No

MRN: _____
STAFF USE ONLY



11) If yes, please answer the following questions:

a. Are there any positions, movements, or situations that make your symptoms worse?
If yes, please explain.

b. When your symptoms occur, how long do they last? (seconds, minutes, hours, days)
If yes, please explain.

c. Do you have visual symptoms? (double vision, difficulty focusing with head movements, blurred vision).
If yes, please explain.

d. Do you have ear symptoms? (fullness, ringing, loss of hearing).
If yes, please explain.

12) What activities (sports, work, household, etc.) are you having a hard time performing / unable to perform because of your symptoms / injury? Please explain.



MEDICAL SYSTEMS REVIEW

Name: _____ Date: _____ Age: _____ Height: _____ Weight: _____

- 1) Are you latex sensitive? ... 2) Do you have a pacemaker? ... 3) Do you smoke? ... 4) Women - Are you currently pregnant? ...

- 5) Have you recently noticed any of the following? Check all that apply: Fatigue, Abdominal Pain, Bleeding/Bruising Easily, Fever/Chills/Night Sweats, Constipation, Nail Bed Change, Weight Loss, Heartburn/Indigestion, Urine Color Change, Fainting/Dizziness, Difficulty Swallowing, Concussion, Nausea/Vomiting, Falls/Loss of Balance, Infection, Headaches, Muscle Weakness, Diarrhea, Coughing/Shortness of Breath, Skin Changes, Changes in Bowel Movements/Bladder Function

- 6) Have you ever been diagnosed with any of the following (Check all that apply): Cancer, Lung Problems, Diabetes, Heart/Cardiac Problems, Tuberculosis, Osteoporosis, Chest Pain/Angina, GERD, Osteoarthritis, High Blood Pressure, Gastrointestinal Problems, Multiple Sclerosis, Rheumatoid Arthritis, Circulation/Vascular Problems, Epilepsy, Blood Clots, Other Arthritic Conditions, Stroke, Ulcers, Bladder/Urinary Tract Infections, Anemia, Kidney Disease/Infection, Hepatitis/Liver Disease, Bone or Joint Infection, Asthma, Sexually Transmitted Disease/HIV, Alcoholism, Pneumonia, Pelvic Inflammatory Disease, Drug Dependency, Spina Bifida, Lupus, Depression, Thyroid Problem, Other: _____

- 7) Has anyone in your immediate family (parents, brothers, sisters) ever been diagnosed with any of the following? (Check all that apply): Cancer, Depression, Diabetes, Heart/Cardiac Problems, Osteoporosis, Thyroid Problems, High Blood Pressure, Blood Clots, Other: _____

8) During the past month have, have you been feeling down or depressed? Yes No

9) Do you feel safe in your home? Yes No

10) Are you limited with the ability to speak English? If so, please include your primary proficient language. No Yes Primary Proficient Language: _____ If you answered yes, are you in need of an interpreter? No Yes

11) Do you have any of the following impairments that require additional accommodations? Deaf or Hard of Hearing Speech Impairments Visual Impairments Mobility Impairments

If you answered yes, please provide the accommodation(s) you need:

MRN: _____ STAFF USE ONLY



Name: _____ Date: _____

MEDICATIONS

List medications (including prescribed pills, skin patches, injections, vitamins/supplements and over the counter medicines) you are currently on and their prescribed purpose. Attach list if needed.

If your primary care physician is from an IHA office this section does not need to be completed.

Medication Name	Dosage/Frequency	Prescribed Purpose	Medication Form <i>Oral, Topical, Inhaled, Injection</i>