



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



### PATIENT QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1) What are your symptoms? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Which of the following best describes how your injury occurred? (Check only one):

- Lifting                       Trauma                       Cumulative Trauma/Overuse
- Car Accident               Degenerative Process       Unknown
- A Fall                       During Recreation/Sports    Running
- Other: \_\_\_\_\_

3) Where did your injury occur?

- At work    Auto    Personal Home    Other Premise: \_\_\_\_\_    Unsure

4) Date of injury/onset of symptoms: \_\_\_\_\_

5) Nature of symptoms (Check all that apply):

- Sharp               Dull               Aching               Tingling
- Occasional       Constant       Throbbing       Other: \_\_\_\_\_

6) Please state your pain level on a scale of 0-10 (0 = no pain, 10 = hospitalized by pain): \_\_\_\_/10

How long does your pain last? \_\_\_\_\_

7) Prior to this onset, were you free of these symptoms?  Yes  No

Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8) Have you had any operations on the body region associated with your present symptoms?

- No    Yes, date: \_\_\_\_\_    Procedure: \_\_\_\_\_

9) Please list any other surgeries you have had: \_\_\_\_\_  
\_\_\_\_\_

10) Does the pain wake you at night?

- Yes \_\_\_\_x/night    No

11) When are your symptoms the most severe?

- Time of day:    Morning       Afternoon       Evening       No difference

- Position:       Sitting       Standing       No difference

MRN: _____
<b>STAFF USE ONLY</b>



12) What makes your symptoms worse? (Check all that apply):

- Sitting
- Going to/from Sitting
- Standing
- Squatting
- Walking
- Sleeping
- Coughing/Sneezing
- Taking a Deep Breath
- Sustained Bending
- Chewing
- Swallowing
- Other: \_\_\_\_\_
- Reaching Out/Overhead
- Reaching Behind Back
- Looking Up Overhead
- Up/Down Stairs
- Up/Down an Incline
- Sports/Recreation Such As: \_\_\_\_\_
- Stress
- Vacuuming
- Doing Dishes
- Making the Bed
- Lying Down

13) What relieves/lessens your symptoms?

- Sitting
- Standing
- Lying Down
- Other: \_\_\_\_\_
- Changing Positions
- Rest
- Alcohol
- Exercise
- Heat
- Cold
- Stretching
- Massage
- Nothing

14) What previous treatment have you had?

- Physical Therapy
- Exercise
- Medication
- Massage Therapy
- TENS Unit
- Traction
- Bracing/Taping
- None
- Other: \_\_\_\_\_
- Injections
- Manipulations/Adjustment by an Osteopath or Chiropractor

15) Have you had any of the following?

- X-rays
- MRI
- CT Scan
- Arthrogram
- Other: \_\_\_\_\_

16) Are you currently working?

- Yes
- No
- Part-time
- Full-time
- Restricted duty
- Occupation (specific): \_\_\_\_\_

17) What positions are you in while working?

- Standing
- Sitting
- Walking
- Bending
- Lifting: \_\_\_\_\_ lbs. \_\_\_\_\_ times a week

18) Please list any activities that you can't do now because of your injury/symptoms: \_\_\_\_\_

19) What goals would you like to achieve from therapy? \_\_\_\_\_



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, etc.

- 6) Have you ever been diagnosed with any of the following (Check all that apply): Cancer, Lung Problems, Diabetes, etc.

- 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, etc.

8) During the past month have, have you been feeling down or depressed? ...

9) Do you feel safe in your home? ...

10) Are you limited with the ability to speak English? If so, please include your primary proficient language. ...

11) Do you have any of the following impairments that require additional accommodations? ...

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>