Trinity Health
Probility Physical Therapy

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**

(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

Probility Physical Therapy

VESTIBULAR PATIENT QUESTIONNAIRE

Name:____ Date: _______________________

1) Briefly explain your current symptoms? ____

2) If you have dizziness, when did it begin? ____

3) Was your first episode of dizziness sudden or gradual?______________________________________

4) Are your present symptoms better, worse or the same?: ____________________________________

5) Are there positions, movements or situations that make your symptoms worse?

If yes, briefly explain: ____

6) When your symptoms occur, how long do they last? (seconds, minutes, hours, days):_____________

7) Do you have visual symptoms? (double vision, difficulty focusing with head movements):

8) Do you have ear symptoms? (fullness, ringing, loss of hearing): _______________________________

9) Do you have history of migraines or headaches?

10) Do you have a history of head injuries, car accidents or episodes of hitting your head?

11) Have you traveled or flown recently?

12) Do you have history of dizziness?

If yes, what previous treatment did you have?: ____

12) Are you taking any medications for your dizziness:

13) Are you in pain?

If so, where?: ____

14) If you have pain, rate it on a scale of 0-10 (0= no pain, 5= moderate pain, 10= worst ever)

MRN: ___________________________

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MEDICAL SYSTEMS REVIEW

Name: ______________________ **Date:** _________ **Age:** ______ **Height:** ______ **Weight:** _______

1) **Are you latex sensitive?** □ Yes □ No

2) **Do you have a pacemaker?** □ Yes □ No

3) **Do you smoke?** □ Yes:___Packs/day □ No

4) **Women – Are you currently pregnant?** □ Yes □ No

5) **Have you recently noticed any of the following? Check all that apply):**

□ Fatigue
□ Fever/Chills/Night Sweats
□ Weight Loss
□ Fainting/Dizziness
□ Nausea/Vomiting
□ Headaches
□ Coughing/Shortness of Breath
□ Abdominal Pain
□ Constipation
□ Heartburn/Indigestion
□ Difficulty Swallowing
□ Falls/Loss of Balance
□ Muscle Weakness
□ Skin Changes
□ Bleeding/Bruising Easily
□ Nail Bed Change
□ Urine Color Change
□ Concussion
□ Infection
□ Diarrhea
□ Changes in Bowel Movements/Bladder Function

6) **Have you ever been diagnosed with any of the following (Check all that apply):**

□ Cancer
□ Heart/Cardiac Problems
□ Chest Pain/Angina
□ High Blood Pressure
□ Rheumatoid Arthritis
□ Blood Clots
□ Ulcers
□ Kidney Disease/Infection
□ Asthma
□ Pneumonia
□ Spina Bifida
□ Depression
□ Lung Problems
□ Tuberculosis
□ GERD
□ Gastrointestinal Problems
□ Circulation/Vascular Problems
□ Other Arthritic Conditions
□ Bladder/Urinary Tract Infections
□ Hepatitis/Liver Disease
□ Sexually Transmitted Disease/HIV
□ Pelvic Inflammatory Disease
□ Lupus
□ Thyroid Problem
□ Diabetes
□ Osteoporosis
□ Osteoarthritis
□ Multiple Sclerosis
□ Epilepsy
□ Stroke
□ Anemia
□ Bone or Joint Infection
□ Alcoholism
□ Drug Dependency
□ 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: ____________________________
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Updated 12.1.25 NRW

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 *Oral, Topical, Inhaled, Injection*

MRN: __________________________
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