Physical Therapy
Qualcare Therapy Center, Inc.

PATIENT REGISTRATION
AUTHORIZATION, ACKNOWLEDGEMENT AND CONSENT

Welcome to our facility. In order to properly serve you, we will need the following information (Please Print.)
All Information will be strictly confidential.

Patient's Name	Sex	Birth Date	Marital Status	
	☐ M ☐ F	____/____/____	☐ Single ☐ Widowed	☐ Married ☐ Divorced

Patient's Address:	City:	State: Zip:

Home Phone:	Cell Phone:	Patient's Social Security No.

If employed, Name of Employer:	Business Phone:
Employer's Address if applicable:	**Occupation:**

Person Financially Responsible	Relationship	Resp Party's Birth date	Resp's Social Security No.
☐ Self ☐ Name:	☐ Spouse ☐ Other	____/____/____	Resp's Phone No.

Reason for Visit:	Referring Physician:	
☐ PT ☐ ~~OT~~ ☐ ~~Speech~~ ☐ ~~Nutritional Counseling~~ ☐ ~~RT~~ ☐ Social Worker Requested ☐ Other: _____	Person to Contact in Case of Emergency:	
	Relationship to Patient:	Emergency Phone Number:

Primary Insurance (ID Card to be photocopied):	Secondary Insurance (ID Card to be photocopied):

Lifetime Assignments of Benefits/Information Release/Authorization to Treat/Acknowledgement/Consent

I authorize payment of medical benefits to QualCare Therapy Center, Inc. for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantee, either expressed or implied, have been made to me regarding the outcome of any medical treatments or procedures. I also authorize the release of test data and billing information to a licensed physician of the facility's choosing for the purposes of professional interpretation and establishment of a diagnosis and treatment recommendations.

I also agree to pay finance charge of 1.5% per month on any balance due over 90 days, as well as all collection, court costs, attorney fees and interest fees accrued with the collection of this account.

Further, I have received copies and read Qualcare's Financial and Payment Policy and Notice of Privacy Practices.

_____ _____

Patient, Parent or Guardian Signature (If patient is under 18 years old) Date

Date: _____

Qualcare Therapy Center, blocks a specific time when a patient schedules for physical therapy session. As a consideration for the Therapist and other patients that could be on a waiting list, I understand that I need to call to inform Qualcare Therapy Center, if I need to cancel or re-schedule my appointment within 24 hrs. I also understand that I can be charge a "No-Show" fee of $50.00 if I don't show up for my appointment.

_____

Print – Patient Name

_____

Patient Signature

Qualcare Therapy Center, Inc.

Initial Examination

Name: _____ **Referral:** _____ **Date:** _____

General Demographics:

Date of Birth: _____ **Age:** _____ **Sex:** ☐ Male ☐ Female

Race/Ethnicity: ☐ Asian ☐ Black ☐ Pacific Islander ☐ Latino
☐ Native American ☐ White ☐ Hispanic ☐ _____

Language: ☐ Speaks english ☐ Interpreter needed
☐ Speaks and Understan ☐ _____

Highest Level of Education: ☐ Grade School ☐ Technical School ☐ Some College ☐ Masters Degree
☐ High School ☐ Trade School ☐ College graduate ☐ _____

Hand/Foot Dominance: ☐ N/A ☐ Ambidexterous ☐ Left ☐ Right

Social History & living Environment:

Referral Source: _____

Where do you live? ☐ Private Home ☐ Rented Home ☐ Extended Care ☐ Hospice
☐ Apartment ☐ Homeless ☐ Board & Care ☐ _____

With whom do you live? ☐ Alone ☐ Relative(s) ☐ Friends ☐ Child or children
☐ Spouse ☐ Parent(s) ☐ Group setting ☐ _____
☐ Partner ☐ Brother(s) ☐ Sister(s)

Does your home have: ☐ One level ☐ Two levels ☐ Multi-levels ☐ Stairs, no railing
☐ Ramps ☐ Elevations ☐ Elevators ☐ Stairs, railing
☐ Uneven terrrain ☐ Any Obstacles (list): _____

How many steps: No. Steps outside the home: _____ No. Steps inside the home: _____

Do you use: ☐ Forearm Crutches ☐ Axillary Crutches ☐ Straight Cane ☐ Walker
☐ Manual Wheelchair ☐ Quad Cane ☐ Two Canes ☐ Rolling Walker
☐ Motor Wheelchair ☐ Glasses ☐ Hearing aids ☐ Other: _____

Cultural/Religious:

Any customs or religious beliefs or wishes that might affect care? _____

_____

_____

Social/Health Habits:

Do you Smoke Tobacco: ☐ No ☐ Occasionally ☐ Socially ☐ Daily ☐ Heavily

Do you Drink Alcohol: ☐ No ☐ Occasionally ☐ Socially ☐ Daily ☐ Heavily

Exercise (beyond normal daily activities & chores)? ☐ No ☐ Yes If Yes, How many days per week: _____ How many minutes per day: _____

Describe exercise or activity: _____

Employment/Work (Job/School/Play):

Work Status: ☐ Unemployed ☐ Working Full-time ☐ Working light duty ☐ Student ☐ Homemaker ☐ Working Part-time ☐ Disabled ☐ Retired

Occupation: _____

Your Work Involves: (Check all that apply)

☐ Prolonged Standing	☐ Working with a bent neck	☐ Lifting Light Objects
☐ Prolonged Sitting	☐ Frequent typing	☐ Lifting Heavy Objects
☐ Prolonged Walking	☐ Repetitive overhead work	☐ Carrying Light Objects
☐ Prolonged Driving	☐ Excessive reaching	☐ Carrying Heavy Objects
☐ Prolonged forward bending	☐ Frequent hand Grasping	☐ Repetitive pushing/pulling
☐ Exposure to vibrating tools	☐ Climbing ladders	☐ Repetitive arm motions
☐ Exposure to temperatures	☐ Excessive stair climbing	☐ Repetitive foot motions

☐ Other: _____

General Health Status:

Please Rate Your Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

Major life changes (past year): ☐ None ☐ Death in Family ☐ New Job ☐ Divorce ☐ New Baby

Family History - Please Check if Anyone in Your Family Has or Had Any or The Following:

☐ Heart Disease ☐ High Blood Pressure ☐ Cancer ☐ Psychological ☐ Pulmonary/Lung Disease

☐ Diabetes ☐ Arthritis ☐ Stroke ☐ Osteoporosis ☐ _____

Past Medical History - Please check if you have or had any of the following (check all that apply):

☐ No Past Medical History	☐ Diabetes	☐ Genetic Disease	☐ Pacemaker
☐ AIDS	☐ Emphysema	☐ Kidney Disease	☐ Parkinson's Disease
☐ Asthma	☐ Epilepsy/Seizures	☐ Liver Disease	☐ Prostate Disease
☐ Arthritis	☐ Glaucoma	☐ Low Blood Pressure	☐ Skin Disorders
☐ Blood Disorders	☐ Heart Attack	☐ Lung Disorder	☐ Stroke
☐ Broken Bones	☐ Heart Disease	☐ Lyme's Disease	☐ Thyroid Disorder
☐ Circulation Problems	☐ Hepatitis	☐ Macular Degeneration	☐ Ulcers (stomach)
☐ Cancer	☐ Head Injury	☐ Muscular Dystrophy	☐ Repeated Infections
☐ Cystic Fibrosis	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ _____
☐ Depression	☐ High Cholesterol	☐ Osteoporosis	☐ _____

Past Medical History - For Women Only:

Pelvic Inflammatory Disease	☐ Yes	☐ No	**Trouble with Period**	☐ Yes	☐ No
Complicated Pregnancies	☐ Yes	☐ No	**Pregnant**	☐ Yes	☐ No
Endometriosis	☐ Yes	☐ No	☐ _____	☐ Yes	☐ No

Surgical History - Please list any surgeries you have had, and if known include dates:

☐ **No Surgeries to Date**

1. _____ **Date:** _____ **2.** _____ **Date:** _____

3. _____ **Date:** _____ **4.** _____ **Date:** _____

Past Symptoms History Checklist - Within the past year, have you had any of the following (check all that apply):

☐ No Symptoms in Past Year	☐ Difficulty Walking	☐ Joint pain or swelling	☐ Tremors
☐ Bowel problems	☐ Dizziness/Blackouts	☐ Loss of Appetite	☐ Urinary problems
☐ Chest Pain	☐ Excessive Sweating	☐ Loss of Balance	☐ Vision Problems
☐ Cough (persistent)	☐ Fatigue	☐ Nausea/vomiting	☐ Weakness in arms/legs
☐ Decreased coordination	☐ Headaches	☐ Numbness in arms/legs	☐ Weight gain (Unexplained)
☐ Difficulty Sleeping	☐ Hearing Problems	☐ Pain at Night	☐ Weight Loss (Unexplained)
☐ Difficulty Swallowing	☐ Heart Palpitations	☐ Shortness of Breath	☐ _____

Diagnostic Tests/Measures - Within the past year, have you had any of the following (Check all that apply):

☐ No Diagnostic Testing	☐ Bronchoscopy	☐ EMG/Nerve conduction	☐ Stool Test
☐ Angiogram	☐ CT Scan	☐ Mammogram	☐ Stress Test
☐ Arthroscopy	☐ Ultrasound	☐ MRI	☐ Urine Test
☐ Biopsy	☐ Echocardiogram	☐ Pap smear	☐ X - Ray
☐ Blood Test	☐ EEG	☐ Pulmonary Function Test	☐ _____
☐ Bone Scan	☐ EKG	☐ Spinal Tap	☐ _____

Medications & Allergies - Please check or list all medications or allergies:

Non-Prescription:	☐ No Medications	☐ Decongestants	☐ Motrin
	☐ Advil/Alleve	☐ Excedrin	☐ Vitamins/minerals
	☐ Antihistamines	☐ Herbal Supplements	☐ Tylenol
	☐ Asprin	☐ Ibuprophen/Naproxen	☐ _____

Prescription: ☐ No Medications ☐ _____

Allergies: ☐ No Known Allergies To Date ☐ _____

Functional Status/Activity Level:

Current Functional Status:

Difficulty with locomotion/movement Such as: ☐ Bed Mobility ☐ Transfers (such as bed to chair, from bed to commode/toilet
☐ Gait (Walking) ☐ on level surfaces ☐ on ramps
☐ on stairs ☐ on uneven surfaces

Difficulty with self care activities such as: ☐ Bathing ☐ Dressing ☐ Toileting

Difficulty with home management such as: ☐ Household Chores ☐ Shopping ☐ Driving/Trasportation ☐ Care of Dependents

Difficulty with community and work activities such as: ☐ Work ☐ School ☐ Recreation ☐ Sport ☐ Play Activity

Prior Functional Status **(Your status prior to the date of onset/injury):**

Prior to your current injury or condition, were you pain free without any difficulty with locomotion/movement, self care activities, home management, community and work activities..... ☐ Yes ☐ No

If No, Please Explain: _____

Current Condition(s)/Chief Complaints:

Nature of Onset/Injury: ☐ Motor Vehicle Accident ☐ Fall ☐ Unknown Onset
☐ Work Related Injury ☐ Traumatic Event ☐ _____
☐ Gradual Onset ☐ Ongoing/Chronic Condition

Date of Onset: _____

Briefly Describe What Happened? _____

Chief Complaints or Problems? _____

Overall How Would You Describe the Intensity of your Symptoms? ☐ Slight ☐ Minimal ☐ Moderate ☐ Severe ☐ Emergency

Overall, How Frequent Are Your Symptoms? ☐ Intermittent (off & on) ☐ Occasionally (sometimes) ☐ Constant (all the time)

Have you ever had this problem(s) before? ☐ Yes ☐ No **What did you do for the problem(s)?** _____

Did the problem get better? ☐ Yes ☐ No **How long did the problem(s) last?** _____

What Makes Your Symptoms Worse? _____

What Makes Your Symptoms Better? _____

What is Your Goal For Physical Therapy? _____

Are You Seeing Anyone Else For Your Problem? ☐ Yes ☐ No **If Yes, Please Check all that Apply.**

☐ Acupuncturist ☐ Cardiologist ☐ Chiropractor ☐ Neurologist ☐ Podiatrist
☐ Family Doctor ☐ Orthopedist ☐ Massage Therapist ☐ Rheumatologist ☐ _____