



# Registration Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Male or Female (circle one)

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Full Time or Part Time or Seasonal or Temporary (circle one)

Injured Body Part: \_\_\_\_\_ Referring Dr: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Privacy Notice: Under the HIPAA Privacy Policy we are required by law to maintain the privacy of your medical records. If you would like a detailed description of this policy please see the front desk. If you are declining a copy of the HIPAA Privacy Policy please sign below.

\_\_\_\_\_  
(Signature of Patient/Guardian)

Please list your contact information which we can leave you messages about your treatment:

Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_ Email: \_\_\_\_\_

### Assignment & Release

I assign directly to North Suburban Physical Therapy all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all medical information necessary to secure the payment of all my insurance submissions. I am responsible for all non sufficient fund checks returned with an additional \$35 fee.

I understand that I am undergoing physical therapy treatment at North Suburban Physical Therapy and I hereby authorize my consent for treatment.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date



# Patient Medical History and Intake Questionnaire

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex : F \_\_\_ M \_\_\_

What is your main complaint and in what area is it located? \_\_\_\_\_

Occupation: \_\_\_\_\_

Are you presently working? Yes \_\_\_\_\_ No \_\_\_\_\_ If no—Last Day Worked: \_\_\_\_\_

Have you ever had these symptoms before? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, When? \_\_\_\_\_

Have you had physical therapy, occupational therapy or chiropractic care for this injury before? Yes \_\_\_\_\_ No \_\_\_\_\_

Which one and when? \_\_\_\_\_

Check all of those which apply to your current condition:

- Work Related Injury                       Sports Injury                                       Fall
- Motor Vehicle Accident                       Aggravation of Pre-Existing Injury                       Causes Unknown
- Injury Recurrence                               Lifting Injury
- Other: \_\_\_\_\_

What have you been doing to decrease your pain? \_\_\_\_\_

**On a scale from 0 (no pain) to 10 (very severe pain), what is your pain level?** \_\_\_\_\_

Are your symptoms getting worse/ better/ the same/ since your injury? \_\_\_\_\_

Are you currently taking any medications? (Please list) \_\_\_\_\_

Are you allergic to any medications? (If yes, please list) \_\_\_\_\_

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Diabetes	_____	_____	Cancer	_____	_____	Metal Implants	_____	_____
Chest Pain	_____	_____	Asthma	_____	_____	Dizziness	_____	_____
Heart Disease	_____	_____	Arthritis	_____	_____	Fractures	_____	_____
Pacemaker	_____	_____	Aids/HIV	_____	_____	Skin Allergies	_____	_____
Headaches	_____	_____	Allergies to Heat	_____	_____	Nausea/Vomiting	_____	_____
Kidney Problems	_____	_____	Allergies to Cold	_____	_____	Ear Ringing	_____	_____
Are You Pregnant	_____	_____	Seizures	_____	_____	Hypoglycemia	_____	_____
Bladder Problems	_____	_____	Respiratory Problems	_____	_____	High Blood Pressure	_____	_____

If you answered yes to any of the above, please explain and give an approximate date of occurrence: \_\_\_\_\_

Please **circle** tests you have had performed:

None      X Rays      MRI      CT Scan      Bone Scan      Other (Explain) \_\_\_\_\_

Check any of the following activities which you have difficulty with due to your injury:

- Housekeeping       Lifting       Driving       Shopping       Reaching
- Dressing       Cooking       Climbing Stairs       Child Care       Bending
- Yard Work       Sit to Stand

List all of your surgeries: \_\_\_\_\_

Is there any other information about your present health that we should know about? \_\_\_\_\_

Date

Patient Signature

PT/OT Initials



## Clinic Policies

Welcome to North Suburban Physical Therapy! Here is some information regarding our patient policies, we hope you will find this helpful.

### Clothing

Appropriate attire typically includes shorts, T-shirts and gym shoes. Tank tops or halter tops are better for neck and shoulder injuries. Elastic waistbands (shorts and sweatpants) are better for people with back and hip injuries. Please make sure that the involved body part and surrounding areas are easily exposed. A washroom is available if you need to change.

### Cancellations/Scheduling

In order to treat your injury in a timely and efficient manner, you are expected to attend all scheduled therapy visits. All cancellations are to be at least *4 hours in advance* and rescheduled within the same business week whenever possible. **THERE WILL BE A \$25 CHARGE TO ALL PATIENTS WHO DO NOT SHOW UP FOR THEIR SCHEDULED APPOINTMENTS.** Three consecutive no-show appointments may result in discharge. \* Please call if you are going to be more than 10 minutes late for your appointments as your treatment program may have to be modified for that particular day.\*

### Worker's Compensation Patients

We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation adjuster and/or case manager of all missed or cancelled appointments. It is also required that all missed visits be rescheduled.

### Billing/Payments

All patient co-pays are to be paid on the same day of your treatment session, unless other arrangements are made with the office manager. All billing questions should be addressed to our office manager. Please inform us immediately if you have made any changes in your address, phone number or insurance carrier. The patient is ultimately responsible for all outstanding balances.

### Personal Items

North Suburban Physical Therapy is not responsible for any lost or stolen items. If you have anything that needs to be secured, please see the Facility Manager.

Thank you for choosing North Suburban Physical Therapy as your physical therapy provider. Our highly skilled staff is looking forward to helping you accomplish your rehabilitation goals in a safe and timely manner.

---

Signature

Date