Appalachian Physical Therapy, Inc.

"There's a difference you can feel"

PATIENT REGISTRATION FORM

Patient's Name_____ ☐ Male ☐ Female
(First) (Middle Initial) (Last)

StreetAddress_____Apt_____Mailing_____

City_____State_____Zip_____

Phone_____ Cell Phone_____Email_____

☐ **Please check this box if you wish to receive our newsletter via the email you provided**

May we leave a message on your: Phone_____ Cell Phone_____ Text Message_____ E-mail_____

Cell Phone Provider _____ (needed for sending appointment reminders)

Social Security_____ Date of Birth_____/____/_____Age_____

Employer _____ Phone _____

Address_____

Is this Worker's Comp.?_____ If yes, contact person work_____Phone_____

Date of injury, if known_____ Referring Physician or Self Referred _____

Person who recommended our services if other than physician_____

Have you been a patient here before? _____ Have you had physical therapy or chiropractic in the past 12 months_____

Spouse's Name _____ Date of Birth ____/____/_____Social Security _____

Spouse's Employer_____Phone_____

Address_____

Spouse/Person to Contact in Case of Emergency_____

Contact's Work Phone_____ Contact's Home Phone_____

I desire that physical therapy services be provided to me and understand it will be my responsibility to pay for these services if my insurance does not pay or if my insurance benefits are paid to me inadvertently. I request that payment of authorized insurance benefits for services be preassigned to Appalachian Physical Therapy.

I understand that any balance remaining on my account after 60 days from the date of service is subject to interest charges at the rate of 2% per month. I understand I am responsible for all registered mail fees, court costs, and attorney fees incurred as a result of collection efforts on this account.

Patient signature_____ Date_____

Patient Representative/Legal Guardian, if applicable_____

PRIVACY PRACTICES

Please review APT's Notice of Privacy Practices provided and initial your desired option below.

☐ *I am aware of APT's Privacy Practices, but decline a personal copy.*

☐ *I am aware of APT's Privacy Practices and request a personal copy.*

PATIENT MEDICAL HISTORY

Name: _____

One of the factors that enables us to provide "a different kind of physical therapy" is our comprehensive, total body approach. We recognize from evidence and experience that the body works as a unit: problems in one area/system can influence another. This is why we ask questions about many body parts and system functions that may seem to have nothing to do with what brings you here. Knowing about past, present, and recurrent issues you have experienced can better direct our treatment of you and lead to a more successful outcome – with your primary complaint as well as issues you may have assumed you had to endure. Thank you for the trust you demonstrate in seeking healthcare from us.

If you do not understand a question, please ask and we will be happy to assist you.

- Are you latex sensitive? Yes No
- Are you allergic to heat or cold on your skin? Yes No Unsure
- Please list any other known allergies: _____
- Are you pregnant or think you might be pregnant? Yes No
- Do you have anything implanted in your body that you were not born with? (Electrical stimulator, metal rods/screws, mesh, cosmetic implants, pacemaker, oral appliance, intra-uterine device, etc.)
  - Yes No
  - If yes, please explain what type and where located: _____
- Do you typically use or wear any type of extrinsic device? (Heel lift, sacral belt, shoe orthotics, removable oral appliance or night guard, etc.)
  - Yes No
  - If yes, please explain: _____

Please indicate if you are currently under the care of any of the following health care providers:

- ☐ PCP (Primary Care Provider: Medical doctor, osteopath, nurse practitioner, physician assistant)
- ☐ Dentist
- ☐ Oral surgeon
- ☐ Orthodontist
- ☐ Psychiatrist/Psychologist
- ☐ Physical Therapist (outside of this organization)
- ☐ Chiropractor
- ☐ Massage therapist
- ☐ Other (please specify): _____ _____ _____ _____

If you have seen any of the above within the last three months, please describe for what reason (illness, medical condition, physical, etc.): _____
_____

MEDICAL/SURGICAL HISTORY

- Please indicate if you experience problems with or have been diagnosed with any of the following conditions:
  - ☐ Arthritis
  - ☐ Broken bones/fractures
  - ☐ Osteoporosis
  - ☐ Blood disorders
  - ☐ Circulation/vascular problems
  - ☐ Heart problems
  - ☐ Hypertension (high blood pressure)
  - ☐ High Cholesterol
  - ☐ Lung problems
  - ☐ Stroke
  - ☐ Diabetes
  - ☐ Hypoglycemia
  - ☐ Thyroid problems
  - ☐ Kidney problems
  - ☐ Head injury
  - ☐ Developmental or growth problems
  - ☐ Multiple sclerosis
  - ☐ Degenerative Disc Disease
  - ☐ Degenerative Joint Disease
  - ☐ Disc Herniation
  - ☐ RLS (Restless Leg Syndrome)
  - ☐ Endometriosis
  - ☐ Organ prolapse
  - ☐ Hernia
    Was it repaired? Yes No
  - ☐ Complications during birth (e.g. premature, low/high birth weight, complications with delivery, etc.)
  - ☐ Muscular dystrophy
  - ☐ Parkinson's disease
  - ☐ Seizures/epilepsy
  - ☐ Skin disease
  - ☐ Cancer
  - ☐ Repeated infections
  - ☐ Depression
  - ☐ Infectious disease
  - ☐ Ulcers/stomach problems
  - ☐ Chemical dependency
  - ☐ Alcohol abuse
  - ☐ Prostatitis
  - ☐ Other: _____ _____ _____

- Are you currently experiencing or do you have a history of any of the following symptoms?
  - ☐ Chest pain
  - ☐ Heart palpitations
  - ☐ Cough
  - ☐ Hoarseness
  - ☐ Shortness of breath
  - ☐ Dizziness or blackouts
  - ☐ Coordination problems
  - ☐ Weakness in arms/legs
  - ☐ Numbness/tingling
  - ☐ Cramping or other symptoms (legs, feet, arms, hands, other)
  - ☐ Loss of balance
  - ☐ Difficulty walking
  - ☐ Joint pain or swelling
  - ☐ Difficulty sleeping
  - ☐ Loss of appetite
  - ☐ Nausea/vomiting
  - ☐ Difficulty swallowing
  - ☐ Bowel problems (constipation, diarrhea)
  - ☐ Acid reflux
  - ☐ Heartburn
  - ☐ Weight loss/gain
  - ☐ Urinary problems (e.g. incontinence/involuntary loss of urine, frequency, urgency, pain, difficulty initiating, need to use bathroom more than once nightly)
  - ☐ Fever/chills/sweats
  - ☐ Headaches
  - ☐ Hearing problems
  - ☐ Vision problems
  - ☐ Fatigue
  - ☐ Sinus problems
  - ☐ Other _____

- If applicable, please answer the following questions regarding pregnancy and childbirth.
  - How many pregnancies have you had? _____
  - How many vaginal deliveries? _____ C-sections? _____ Episiotomies? _____
  - Have you had any complications with or since any childbirth? Yes No
    - If yes, please explain: _____
      _____

- Please indicate if you have ever had imaging performed, the approximate date(s), and to what body part(s).
  - ☐ MRI _____
  - ☐ X-Rays _____
  - ☐ CT Scan _____
  - ☐ Other_____

  Where were the test(s) performed? RMH UVA Doctor's Office Other_____

- Please list any surgeries or hospitalizations, including the approximate date and reason:
  _____
  _____
  _____

- Please describe any significant injuries for which you have been treated and the approximate date of injury:
  _____
  _____
  _____
  _____

- Have you ever been involved in a motor vehicle accident with injury (even minor)? ☐ Yes ☐ No
  If yes, please list the approximate date(s): _____

FAMILY HISTORY

- Please indicate whether anyone in your immediate family (parents, siblings, grandparents) have been diagnosed with the following and list the age of onset if known:
  - ☐ Heart disease _____
  - ☐ Hypertension _____
  - ☐ Stroke _____
  - ☐ Diabetes _____
  - ☐ Cancer _____
  - ☐ Psychological _____
  - ☐ Arthritis _____
  - ☐ Osteoporosis _____
  - ☐ Other: _____

MEDICATIONS

- Please list here any prescription medications you are currently taking (or provide us with a separate list): _

  _____

  _____

  _____

  - Are you taking any of the following nonprescription medications?

☐ Aspirin	☐ Decongestants
☐ Advil/Aleve/Motrin/Ibuprofen	☐ Laxatives
☐ Tylenol	☐ Antacid
☐ Antihistamines	☐ Vitamins
☐ Herbal supplements	☐ Other: _____

SOCIAL/HEALTH HABITS

- Do you currently use tobacco products? ☐ Yes ☐ No
  - If yes, how many packs per day do you smoke? _____
- Have you used tobacco products in the past? ☐ Yes ☐ No
  - If yes, in what year did you quit? _____
- How many caffeinated beverages do you drink per day? _____
- Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No
  - If yes, please describe the type of exercise, how many times per week, and for how long each day.

    _____

Patient Signature: _____ Date: _____

PROVIDER NOTICE
OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: We use health information about you for treatment, billing, and healthcare operations. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. We will not sell or use your health information without your authorization.

Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we may charge you a fee. You also have the right to receive a list of certain types of disclosures of your information that we made. You have the right to receive a copy of your healthcare record in a machine electronic format or a hard copy if a machine readable format is not available. We will complete your request within 30 days. You have the right to restrict the disclosure of healthcare information when payment for an item or service is paid out of pocket. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. If we make a significant change in our policies, we will change our notice and post the new notice. We will notify affected individuals of a breach of unsecured protected healthcare information. *You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.*

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:
Privacy Officer: Colleen Whiteford
Address: 171 East Springbrook Road
Broadway, VA 22815
Phone: (540) 901-9501

Acknowledgement of receipt of Notice of Privacy Practices:
Please sign your name and print your name and date on this acknowledgement form.

Patient Signature:_____ Date: _____

Printed Name:_____

Patient Representative/Legal Guardian, if applicable:_____

Name:_____ Date:_____

Pain and/or Symptom Numeric Rating Scale

1. On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst pain imaginable, how would you rate your pain RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

2. On the same scale, how would you rate your BEST level of pain during the last week.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

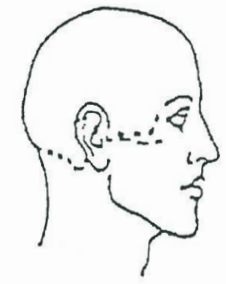
3. On the same scale, how would you rate your WORST level of pain during the last week.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

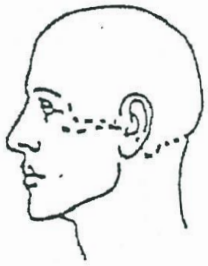
Name:_____ Date:_____

PLACE MARK ON BODY ACCORDING TO YOUR PAIN/SYMPTOMS
USE THE FOLLOWING KEY:

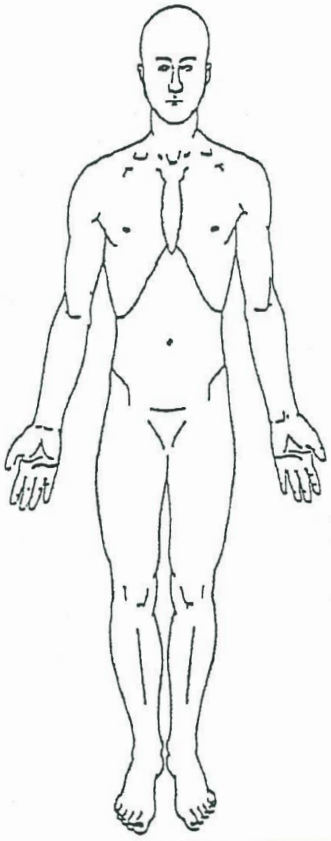
//// Sharp, intense pain
XXX Dull aching, soreness
OOO Numbness, tingling, pin, and needles sensation



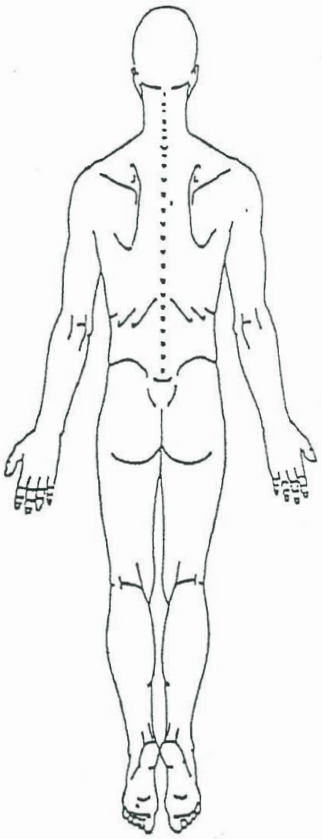
Right



Left



Right Left



Left Right

Which activities or positions make you feel worse? _____
_____

Which activities or positions make you feel better? _____
_____

PAIN SCALE: Please select a number from 0 to 10 which best describes your pain level with 0 being no pain and 10 being the worst imaginable pain

At the present time:____ Worst in the past 24 hours:____ Best in the past 24 hours:____