



Appalachian Physical Therapy, Inc.

"There's a difference you can feel"

PATIENT REGISTRATION FORM

Patient's Name _____ Male Female
(First) (Middle Initial) (Last)

Street Address _____ 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> PCP (Primary Care Provider:
Medical doctor, osteopath, nurse
practitioner, physician assistant) | <input type="checkbox"/> Psychiatrist/Psychologist
<input type="checkbox"/> Physical Therapist
(outside of this
organization) | <input type="checkbox"/> Other (please specify): _____

_____ |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Chiropractor | |
| <input type="checkbox"/> Oral surgeon | <input type="checkbox"/> Massage therapist | |
| <input type="checkbox"/> Orthodontist | | |

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:

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

- Are you currently experiencing or do you have a history of any of the following symptoms?

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Weight loss/gain
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Urinary problems (e.g. incontinence/involuntary loss of urine, frequency, urgency, pain, difficulty initiating, need to use bathroom more than once nightly)
<input type="checkbox"/> Cough	<input type="checkbox"/> Joint pain or swelling	
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Difficulty sleeping	
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Loss of appetite	
<input type="checkbox"/> Dizziness or blackouts	<input type="checkbox"/> Nausea/vomiting	
<input type="checkbox"/> Coordination problems	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Fever/chills/sweats
<input type="checkbox"/> Weakness in arms/legs	<input type="checkbox"/> Bowel problems (constipation, diarrhea)	<input type="checkbox"/> Headaches
<input type="checkbox"/> Numbness/tingling	<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Cramping or other symptoms (legs, feet, arms, hands, other)	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Vision problems
		<input type="checkbox"/> Fatigue
		<input type="checkbox"/> 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:

<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Psychological _____
<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Arthritis _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Osteoporosis _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cancer _____	

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?

- | | |
|---|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Decongestants |
| <input type="checkbox"/> Advil/Aleve/Motrin/Ibuprofen | <input type="checkbox"/> Laxatives |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Antacid |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Herbal supplements | <input type="checkbox"/> 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: _____

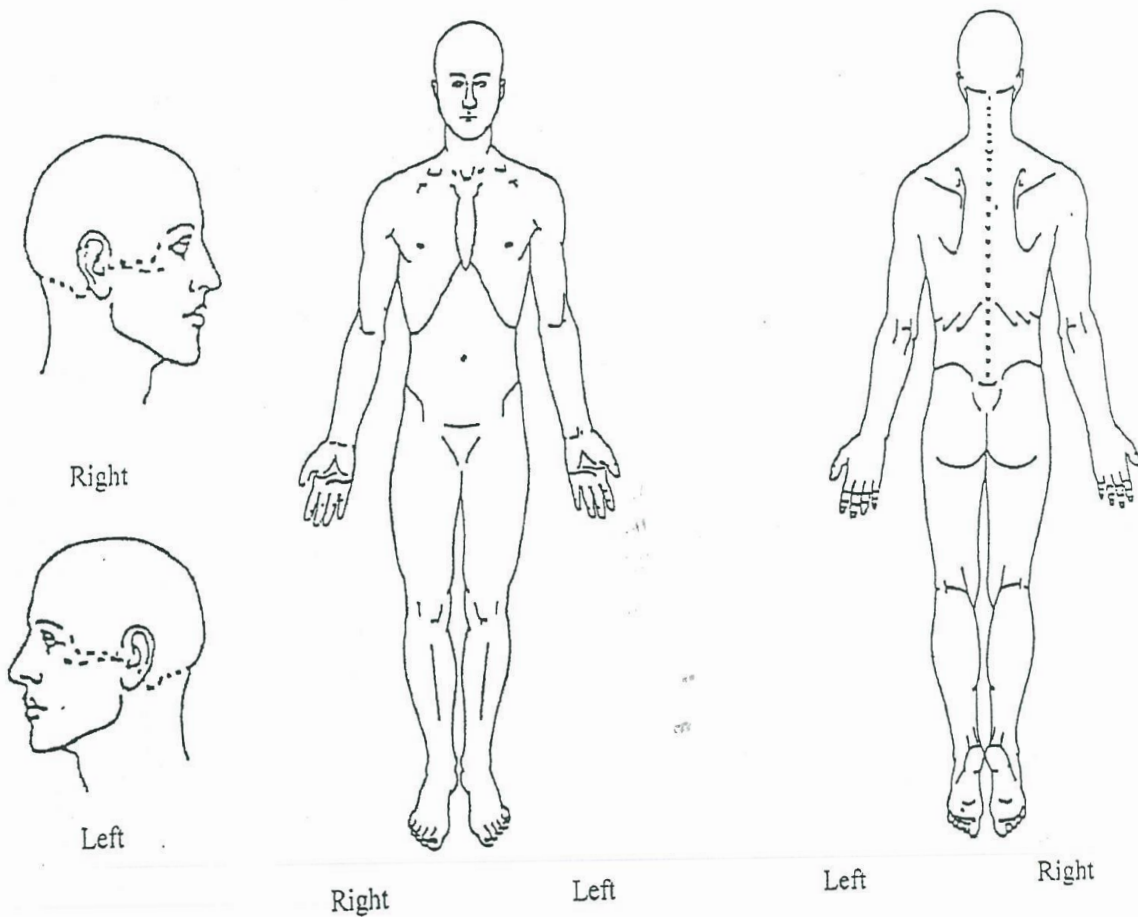
Printed Name: _____

Patient Representative/Legal Guardian, if applicable: _____

Name: _____ Date: _____

**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



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: _____



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Cancellation/No Show Policy

Appalachian Physical Therapy's cancellation/no show policy is as follows:

No shows: after the 2nd no show you will not be set up for another appointment before paying a \$50 fee at which point one (1) appointment will be set.

Cancellations: After cancelling two (2) appointments without 24 hours' notice a \$50 cancellation fee will be charged for each subsequent cancellation. Habitual cancellations will result in an inability to schedule further appointments without paying a \$50 fee, at which point one (1) appointment will be set. Cancellations due to medical emergencies are not subject to the above policy; but a physician's note is required.

Appalachian Physical Therapy's policy is to administratively discharge patients who cancel or no show several appointments (3) and no further contact has been received or pre-payment made.

Patient's Signature: _____

Date: _____