TALARIA PHYSICAL THERAPY & WELLNESS

REGISTRATION FORM

(Please Print)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	Mr. Mrs.	Miss Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Email:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Work phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Internet	☐ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Name of Insurance Company:	Provider Services Phone # (on back of card):

Subscriber's name:	Birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Talaria Physical Therapy, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Medical History Form

Name:_____Date of Birth:_____Date: _____

History of Current Problem(s)

The date your problem(s) began (month/date/year): _____

What happened? _____

Have you ever had the problem(s) before?

☐ **Yes** Did the problem(s) get better? ☐ **Yes** ☐ **No**

About how long did it last? _____

☐ **No**

How are you taking care of the problem(s) now? _____

What makes the problem(s) worse? _____

What activities are you not able to do now that you could do before the problem(s)? Please be as specific as you can; for instance, "unable to reach over my head." _____

_____

What are your goals for therapy? _____

Have you ever received physical therapy? ☐ **Yes** ☐ **No** If so, when and why? _____

_____

Are you seeing another professional for the problem(s)? Check all that apply:

☐ Acupuncturist	☐ Occupational Therapist	☐ Cardiologist	☐ Orthopedist
☐ Chiropractor	☐ Osteopath	☐ Dentist	☐ Pediatrician
☐ Family Practitioner	☐ Internist	☐ Neurologist	☐ OBGYN
☐ Rheumatologist	☐ Podiatrist	☐ Massage Therapist	☐ Other

Current Limitations. Please Check all that apply below.

☐ Difficulty with locomotion and/or movement:

- ☐ Bed Mobility
- ☐ Transfers (such as moving from the bed to a chair, bed to commode)
- ☐ Gait (walking)
  - ☐ On level ☐ Stairs ☐ Ramps ☐ Uneven terrain

☐ Difficulty with self-care (bathing, dressing, eating, toileting)

☐ Difficulty with home management (household chores, shopping, driving)

☐ Difficulty with community and or work activities

☐ Difficulty with recreation sports

☐ Other _____

Employment

Occupation_____

☐ Full time ☐ Part time ☐ Full Duty/Modified Duty

Currently not working due to: ☐ Injury/Surgery ☐ Other _____

Home Environment:

What type of home do you live in?

☐ One floor home ☐ More than one floor ☐ Stairs with railing ☐ Without railing ☐ Elevator

With whom do you live? ☐ Alone ☐ Spouse only ☐ Family Members ☐ Other _____

Medications

Please list all prescription medications _____

_____

List all over-the-counter medications _____

_____

Medical History: Please check if you have ever had:

☐ Developmental or growth problems	☐ Kidney problems	☐ Broken bones
☐ Circulation/vascular problems	☐ Infectious disease	☐ Arthritis
☐ Low Blood Sugar/Hypoglycemia	☐ Lung problems	☐ Allergies
☐ Alcohol/Drug dependency	☐ Muscular Dystrophy	☐ Osteoporosis
☐ Repeated infections	☐ Seizures/Epilepsy	☐ Depression
☐ Ulcers/Stomach problems	☐ Blood disorders	☐ Head injury
☐ Diabetes/high blood sugar	☐ Multiple Sclerosis	☐ Cancer
☐ High Blood Pressure	☐ Stroke	☐ Parkinson's Disease
☐ Skin Diseases	☐ Other	

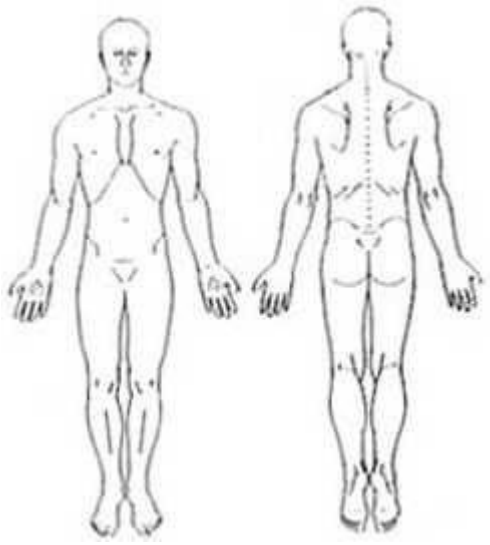
Surgeries

Please list any surgeries including year:

_____

_____

Please mark on the drawings below, the areas where you feel pain.



Pain Scale: On the line provided, please make where your "pain status" is today.

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No Pain Most Severe Pain

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individuals' home.

I wish to be contacted in the following manner (check all that apply):

□ Home Telephone_____
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only.

□ Work Telephone _____
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only

□ Written Communication
- □ O.K. to mail to my home address
- □ O.K. to mail to my work/office address
- □ O.K. to fax to this number _____

□ Other _____
_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records; P =Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; M=Mail; O=Other