Patient] _____ Account #:_____ Case:_____ Location:_____ IE Date:_____

Wholistic Physical Therapy

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name	First	MI	Female ( ) Male ( )	Birth Date	Age	Cell Phone#
Address		Apt#	City	State	Zip	
SSN - Last 4 (Legal Guardian's if under 18):	Employer Name :		Employer # :		Marital Status	
E-Mail	Home Phone#		Primary Care Physician		Phone#	

Cell Phone Disclaimer: If you have included a Cell Phone number, you are giving our office or agent permission to call that phone.

Emergency Contact	Relationship	Cell Phone#

INSURANCE

Primary Insurance — **Claims Mailing Address (Listed on back of card)**

Policy#	Group#	Effective Date
Policy Holder Name	DOB	Relationship to Patient

Secondary Insurance — **Claims Mailing Address (Listed on back of card)**

Policy#	Group#	Effective Date
Policy Holder Name	DOB	Relationship to Patient

OTHER INSURANCE

Do you have work/auto **claim** information? ( ) Y ( ) N If Yes - circle one: Work Auto	Date of injury	Claim#
Insurance Name & Claims Mailing Address		
Attorney/Adjuster Name	Attorney/Adjuster Phone#	

UNIFORM OF ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL DISCLOSURE:

All information provided herein is true and correct. I give permission to Wholistic Physical Therapy to release/obtain information, verbal and written, contained in my medical record, and other related information to/from my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related person, as needed. I authorize direct payment to Wholistic Physical Therapy for services provided. I acknowledge that I am responsible for all account totals and balances. I promise to notify Wholistic Physical Therapy if at any time there is a change in my Insurance Policy(s) or Benefits. I expressly guarantee payment of the account/dependent named above, and agree to pay any charges left unpaid in whole or in part by the insurance company. **Cash Based Physical Therapy Packages & Sessions sales are final and no refunds will be issued.** I understand packages do not expire, and can only be redeemed at the original location of purchase and that any unused sessions are transferable to family/friends at the original location of purchase ***only***. I certify all information given is accurate. I certify that I have read and fully understand the above consents. I**f the patient is a minor, their Legal Guardian must sign below.**

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

MEDICAL HISTORY

Patient Name: _____ Acct #: _____ Case#: _____ Date: _____

By taking the time to complete this form, you will be assisting us in planning your physical therapy treatment. Please be as thorough as possible. If there is information relevant to your treatment not outlined below, please bring it to the attention of your physical therapist. Your cooperation is greatly appreciated.

Current Condition(s)/Chief Complaint(s)

Reason for referral to physical therapy: _____

Date of injury or onset of the problem: _____

Location of pain: _____

Is your current pain: Intermittent ☐ **Constant** ☐

Do you have any of the following symptoms: Numbness ☐ **Tingling** ☐

Have you experienced any of the following?

Changes in bowel or bladder function ☐
Non-healing sores or wounds ☐
Pain that is worse during rest vs. activity ☐
Fatigue ☐
Fever/Sweats ☐
Unexplained significant lower or upper limb weakness ☐
Pain that is worsened at night or not relieved by any position ☐
Unexplained weight loss ☐
Referred or radiating pain ☐

Have you received physical therapy in the past 12 months? ____ Yes ____ No

If yes, where and for what? _____

Please describe the treatment: _____

Functional Status and Activity Level

Prior to the condition or injury, please rate your functional status with self-care and home management activities:

Excellent ☐ Good ☐ Fair ☐ Poor ☐

Please rate your current functional status with self-care and home management activities:

Excellent ☐ Good ☐ Fair ☐ Poor ☐

Family/Social History

Do you live alone? ____ Yes ____No **If No, with whom do you live?** _____

Are you currently working? ____Yes ____ No **What is your occupation?** _____

Pertinent Family History _____

Living Environment

In which type of home do you live? ☐ 1-story home ☐ 2-story home ☐ Apartment ☐ Tri-level Other: _____

Are there stairs in the home or in order to get into the home? ____ Yes ____ No

If yes, number of steps: ____ Hand Railing present on: ☐ Right side ☐ Left side ☐ Both sides ☐ No hand railing

General Health Status

Height _____ Weight:_____

What type of exercise or activity did you participate in prior to this condition? _____

_____

How often did you participate in this activity or form of exercise? ☐ 5-7 times per week ☐ 3-5 times per week ☐ 1-2 times per week ☐ 1-2 times every other week ☐ Once per month ☐ Other Please Specify: _____

Do you smoke? ☐ Yes ☐ No If yes: less than 1 pack per day ☐ or more than 1 pack per day ☐

How often do you drink alcohol? ☐ Zero ☐ Less than 1 day ☐ 1-2 days ☐ 3-4 days ☐ 5-7days

Are you pregnant? ____ Yes ____ No **Physician:** _____

Patient Name: _____ Acct #: _____ Case#: _____

Have you ever had surgery? ☐ Yes ☐ No
If yes, please list what type and the date(s)? _____
What activities has your doctor instructed you to limit or avoid? _____

Do you have a follow up appointment scheduled with your doctor? Date: _____

Have you had a flu shot recently? ☐ **Yes** ☐ **No If yes, when:** _____

Other Clinical Tests

Have you had any of the following performed since your injury:
X Rays: ☐ MRI: ☐ Bone Scan: ☐ CAT scan: ☐ Comments: _____

_____

Please list your current physicians: _____

_____

_____

Who can we speak with regarding your treatment and billing? _____ _____
Contact Name **Phone Number**

Current Medication List: See Medication List Provided ☐

Medication	Dose	Frequency

Consent For Care And Treatment & Acknowledgment of Receipt of Notice of Privacy Practices

I give consent for Wholistic Physical Therapy to furnish medical care and treatment considered necessary and proper in treating my physical condition. The undersigned Patient/Guardian acknowledges he/she has been personally advised that copies of Wholistic Physical Therapy's Notice of Privacy Policies are posted at the point of care and that copies are available upon request.

Name: _____ **Signature:** _____ **Date:** _____

HealthQuest COVID-19 Questionnaire

Updated August 2nd, 2020

The safety of our employees, customers, families and visitors remain Wholistic Physical Therapy's overriding priority. As the COVID-19 outbreak continues to evolve and spreads globally, HealthQuest's COVID-19 Response Team is monitoring the situation closely and will periodically update company guidance based on current recommendations from the Center for Disease Control (CDC). Only *business-critical visitors are permitted at any Wholistic Physical Therapy facility at this time.

To prevent the spread of COVID-19 and reduce the potential risk of exposure to our colleagues and visitors, we are conducting a simple visitor screening questionnaire. Your participation is required to help us take precautionary measures to protect you and everyone at our locations.

Visitor Name:	Personal Phone Number (mobile/home):

Self-Declaration by Visitor
1- Have you been in close contact (<6ft) for a prolonged period (>15 minutes) with a +COVID-19 case within the last 14 days? Circle one: **YES** **NO**
2- Have you ever been diagnosed with COVID-19? **YES** **NO**
3- Have you experienced any cold or flu-like symptoms in the last 14 days (to include fever, cough, sore throat, respiratory illness, difficulty breathing)? **YES** **NO**

If the answer is "yes" to any of these questions, special considerations will be made in coordination with our Clinical Director to coordinate plans to ensure that you get the care that you need.

Note: During your episode of care with us, your temperature will be taken and you will be asked if there are any changes to your responses each time you arrive. All visitors will be handled the same. The information collected on this form will be used to determine the best course of action regarding your treatment.

Signature (WPT Representative): _____ Date: _____

If Visiting, Who are you here to see: _____

Special Accommodations Needed: Yes No

Plan for Accommodations:
