PATIENT REGISTRATION and MEDICAL HISTORY

DATE: ___ / ___ / ___

Patient Name:	S.S. #:	Date of Birth:	Age:
Address	City State Zip	Home Phone:	
Email address:		Cell Phone:	
Employer:	Occupation:	Work Phone:	
Emergency Contact Name:	Relationship to Patient:	Phone:	
Referring Physician:	Primary Care Physician (if different):		
Have you recently or are you currently being treated by Home Health therapist, nurse, etc..? Yes No			
Date of Injury (if applicable):	Date of Surgery (if applicable):		

Your Chief Complaint: _____

_____

Any Past Treatment (if so, what)? _____

_____

Any Previous Tests & Results? _____

_____

Any Previous Surgeries? _____

_____

Current Medications: _____

_____

What are your goals for therapy? _____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION

This document will authorize **Next Step Rehabilitation** to release and receive any pertinent information and to maintain communication between the physician's office and physical therapist that may assist in the evaluation and subsequent care:

☐ Referring Physician: _____

☐ Primary Care Physician: _____

☐ Other: _____

This consent will expire upon satisfaction of the need for disclosure, not to exceed 120 days after the date signed. I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose(s), this consent will automatically expire without my express revocation.

_____ _____ _____

Patient/Guardian/Responsible Party Date

_____ _____ _____

Witness Date