*Next Step Rehabilitation*

**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..?       |
| Date of Injury (if applicable):       | Date of Surgery (if applicable):       |

|  |  |
| --- | --- |
| Your Chief Complaint: |       |
|  |
| Any Past Treatment (if so, what)? |       |
|  |
| Any Previous Test & 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 receiver 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 |