*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 |