miller physical therapy

REGISTRATION FORM

NAME____ Male Female

First MI Last

ADDRESS__________________________CITY_______________STATE_____ZIP______

PHONE (Home)_______________ (Cell)________________ (Work)__________________

DATE OF BIRTH_______________AGE______MARITAL STATUS__________________

SOCIAL SECURITY #______-_____-__________EMAIL ADDRESS__________________

PLACE OF EMPLOYMENT (OCCUPATION)_____________________________________

EMERGENCY CONTACT____________________________PHONE__________________

RELATIONSHIP TO PATIENT____

ATTORNEY NAME_________________________________PHONE__________________

REFERRING PHYSICIAN____

PRIMARY CARE PHYSICIAN____

HOW DID YOU HEAR ABOUT US?____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform **miller physical therapy** of any changes that occur. I authorize release of payment directly to **miller physical therapy** regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient / Parent / Guardian Signature:_________________________________Date:______________________

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient / Parent / Guardian Signature:_________________________________Date:______________________

"WHERE FITNESS AND WELLNESS MEET"

MEDICAL HISTORY FORM

WHAT IS YOUR CONDITION / INJURY?______________________________

DATE OF ONSET OF SYMPTOMS:________________ CURRENT WORK STATUS________________

HAVE YOU HAD PHYSICAL THERAPY FOR THIS CONDITION IN THE PAST? IF SO, WHERE AND WHEN?________

____

IS THIS INJURY A RESULT OF A CAR ACCIDENT? YES NO

HAVE YOU HAD SURGERY FOR THIS CONDITION? YES NO

TYPE OF SURGERY AND DATE OF SURGERY:______________________________

HAVE YOU HAD ANY DIAGNOSTIC TESTS FOR THIS INJURY? YES NO

IF SO, WHAT TYPE? (I.E., X-RAYS, MRI, EMG, OTHER) AND RESULTS:____________________

LIST ANY MEDICATIONS THAT YOU ARE TAKING______________________________

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- □ ARTHRITIS
- □ BROKEN BONES / FRACTURES
- □ CANCER
- □ DIABETES
- □ HEART PROBLEMS
- □ HIGH BLOOD PRESSURE
- □ LUNG PROBLEMS
- □ SEIZURES
- □ STROKE
- □ HEAD INJURY
- □ MULTIPLE SCLEROSIS
- □ MUSCULAR DYSTROPHY
- □ PARKINSON'S DISEASE
- □ OSTEOPOROSIS
- □ OTHER:______________________________

ARE YOU HAVING ANY OF THESE SYMPTOMS? (CHECK ALL THAT APPLY)

- □ CHEST PAINS
- □ COORDINATION PROBLEMS
- □ DIFFICULTY SLEEPING
- □ HEADACHES
- □ LOSS OF BALANCE
- □ PAIN AT NIGHT
- □ VISUAL PROBLEMS
- □ WEAKNESS
- □ OTHER:______________________________

CURRENT LIMITATIONS (CHECK ALL THAT APPLY):

- □ DIFFICULTY WITH WALKING
- □ DIFFICULTY WITH STAIRS
- □ DIFFICULTY WITH BATHING, DRESSING
- □ DIFFICULTY WITH DRIVING
- □ DIFFICULTY WITH CHORES, SHOPPING
- □ DIFFICULTY WITH WORK, SCHOOL
- □ DIFFICULTY WITH RECREATIONAL ACTIVITIES
- □ OTHER:______________________________

PATIENT NAME (PRINT):______________________________

PATIENT SIGNATURE:________________________ DATE:________________