FYZICAL
Therapy & Balance Centers

PATIENT REGISTRATION FORM

Patient Information			
Last Name	**First Name**		**Middle Initial**
Mailing Address			**Apt #**
City	**State**	**Zip**	
Date of Birth	**Gender** Female Male	**Social Security Number**	
Home Phone	**Cell Phone**	**Email**	
Preferred Method of Contact Phone Email	**Primary Doctor**	**Referring Physician**	
Emergency Contact	**Phone**	**Relationship**	
Have you had Home Health in the past 12 months? Yes No	**Have you had any physical, occupational, or speech therapy this year?** Yes No	**How did you hear about Fyzical?**	
Spouse and or Guardian Information			
Name	**Relationship**	**Date of Birth**	
Mailing Address		**Social Security Number**	

Consent for Treatment:
I hereby consent to receive care for therapy services by FYZICAL. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.**Consent to Release Medical Information:** I authorize FYZICAL to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and _____. **Consent to Obtain Medical Information:** I authorize FYZICAL to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, CAT scans, and MRI reports, along with Physician's documentation. **Assignment of Insurance Benefits:** I hereby authorize payment to be made directly to FYZICAL. **Guarantee of Payment**: I agree to pay any charges that my insurance does not pay. I am responsible to pay any uncovered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.
Cancellation No Show Policy: I understand that my appointment is a reservation of time with a skilled health professional. Insufficient notice of missing an appointment detracts from my ability to get fully well and affects other patients as well. Appointments without sufficient notice (Less than 24 hours) will be charged a $25 fee. A no-show without any notice will incur a $35 fee. My insurance does not cover these fees and it will be my responsibility to pay. If I repeatedly neglect my appointments, the office may dismiss me as a patient.
I hereby certify that I understand these rights as set forth.
I acknowledge that I have been informed of FYZICAL's Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information.
I have received a copy of the patient's rights and responsibilities handout: YES☐ NO☐

Patient/Responsible Party Signature: _____ Date: _____
Legal Representation (if applicable) Name: _____ Signature: _____

FYZICAL
Therapy & Balance Centers

Patient Name: _____ Date: _____

Personal Information

Height ___ ft ___ in Weight _____ **Preferred Language:** ☐English ☐Spanish ☐Other

Employment Status

☐ Employed full-time ☐ Employed part-time ☐ Student ☐ Retired ☐ Homemaker
☐ Unemployed ☐ Disabled ☐ Not working because of current illness/injury

If you are currently employed, what best describes your job?

☐ Desk work ☐ Manual Labor

Marital Status

☐ Single ☐ Married

Living Situation

☐ Live alone ☐ Live with spouse/family ☐ Assisted-living facility

Medical History

Past	Present		Past	Present	
☐	☐	High blood pressure	☐	☐	Heart attack
☐	☐	Diabetes	☐	☐	Neuropathy
☐	☐	Pacemaker	☐	☐	Epilepsy/seizures
☐	☐	Stroke/TIA	☐	☐	Arthritis: osteo/Rheumatoid
☐	☐	Vertigo	☐	☐	Hearing Loss
☐	☐	Asthma	☐	☐	Pregnancy
☐	☐	HIV/AIDS	☐	☐	Bowel/bladder problems
☐	☐	Cancer	☐	☐	Tobacco use
☐	☐	Tumor	☐	☐	Drug or alcohol dependence
☐	☐	Concussion	☐	☐	Other:_____

Have you fallen in the last 12 months?

☐ NO ☐ YES If yes, how many times? _____

List any medications you are currently taking, including name, dosage, and frequency:

_____

_____

_____

List any surgeries you have had, including the year:

_____

_____

_____

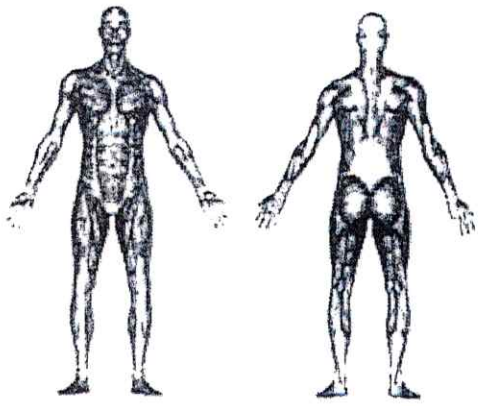
FYZICAL Therapy & Balance Centers

Patient Name: _____ Date: _____

Describe the location of your pain:

☐ Neck	☐ L	☐ R	☐ Both
☐ Back	☐ L	☐ R	☐ Both
☐ Shoulder	☐ L	☐ R	☐ Both
☐ Elbow	☐ L	☐ R	☐ Both
☐ Wrist	☐ L	☐ R	☐ Both
☐ Hip	☐ L	☐ R	☐ Both
☐ Knee	☐ L	☐ R	☐ Both
☐ Ankle	☐ L	☐ R	☐ Both
☐ Foot	☐ L	☐ R	☐ Both

☐ Other: please mark on the picture.



Describe the nature of your pain:

☐ Achy	☐ Burning	☐ Dull	☐ Numbnes
☐ Sharp	☐ Shooting	☐ Throbbing	☐ Tingling

How long ago did your pain start?: _____

Prior to the onset of your symptoms, how would you rate your level of function? (circle #):

Lowest 0 1 2 3 4 5 6 7 8 9 10 Highest

How often do you experience pain symptoms?

☐ Constantly ☐ Hourly ☐ Daily ☐ Other: _____

Rate your level of pain at its worst, at its best, and at its current level, where 0 = no pain (circle #):

Worst	0	1	2	3	4	5	6	7	8	9	10
Best		0	1	2	3	4	5	6	7	8	9	10
Current	0	1	2	3	4	5	6	7	8	9	10

Have you had surgery?

☐ Yes ☐ No Date: _____ Procedure: _____

Do you currently take any medications for this pain?

☐ Yes, with some pain relief ☐ Yes, but without pain relief ☐ No

If yes, please include medication information below:

Name of medication: _____

Dosage: _____

Frequency: _____