SporTherapy
Physical Therapy and Sports Medicine

Patient Registration Form – Self Pay

Patient Name:	Preferred:
Address, City, State, Zip:	
DOB:	Social Security #:
Email Address:	

Home Phone:	Appointment Reminder Method
Cell Phone:	□ Home Phone □ Cell Phone
Work Phone:	□ Work Phone

Please keep in mind that communication via email over the Internet is not a secure form of communication. By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Partner's Name:	
Financial Responsibility: ☐ Self ☐ Other, Please List Parent/Legal Guardian Name:		
Address and Phone Number, If Different from Above:		
Social Security #:	DOB:	Relation:
2nd Contact Info and Phone:		Relation:
General Physician:	Referred by:	

Have you had Physical Therapy treatment since January of this year? ☐ Yes ☐ No If yes, # of Visits:
Have you had Chiropractic treatment since January of this year? ☐ Yes ☐ No If yes, # of Visits:
Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ No If yes, Home Healthcare Provider:

Consent to Treat/Acknowledgements

I hereby authorize and consent to treatment/services for myself, or on the behalf of the above-named patient performed by the staff at SporTherapy and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I certify that the information I have provided is accurate and complete. In signing this form, I will promptly pay any required amounts due at the time services are rendered.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

_____ _____

Signature of Patient/Guardian Date

_____

Print Name and Relationship to the Patient

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Patient Elect to Self-Pay for Services

If you do not have personal health insurance OR you do not want SporTherapy to file claims to your personal health insurance, please read and sign below.

I acknowledge that I understand and agree that:

- ✓ SporTherapy is a participating provider with Health Plan.
- ✓ I am covered by the health insurance plan.
- ✓ The Health Plan under which I am covered includes benefits for some or all the services provided by SporTherapy.
- ✓ Despite the above, I do not wish SporTherapy to submit a claim to my Health Plan for services provided to me.
- ✓ Until such time as I may otherwise advise SporTherapy in writing, I elect to pay for all services I receive at their self-pay rates.
- ✓ By election to self-pay for services, any payments I make to SporTherapy will not be credited toward satisfying any deductible I may be subject to under my Health insurance plan unless otherwise permitted under the terms of my Health plan.
- ✓ I have read this Election to Self-Pay for Services and have had the opportunity to ask any questions I may have, and my questions have been answered to my satisfaction.
- ✓ I have freely chosen to self-pay for services after having asked SporTherapy about payment options and having carefully considered those options.

Patient/Guardian Signature: Date:

Photo/Video Release

I grant to SporTherapy and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and/or videos of me inconnection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs and/or videos of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content and waive any right to compensation, therefore I understand that I may revoke this authorization but only in writing delivered to the clinic Office Manager. I understand that if I choose to revoke this authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this authorization.

(Please check a box below)

☐ Agree ☐ Decline

Patient/Guardian Signature: Date:

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PATIENT HEALTH QUESTIONNAIRE

Patient Name: **Preferred Name:**

Occupation: Height: Weight: Sex: ☐ Male ☐ Female

Leisure Activities/Hobbies:

Are you? ☐ Right-handed ☐ Left-handed

Where do you live? ☐ Private Home ☐ Apartment/Rented Room ☐ Assisted Living/Group Home
☐ Hospice ☐ Other:

With whom do you live? ☐ Alone ☐ Spouse Only ☐ Spouse and Others ☐ Child
☐ Other:

Does your home have? ☐ Stairs, No Railing ☐ Stairs, Railing ☐ Ramps ☐ Uneven Terrain
Please Explain:

How many times have you fallen in the past 12 months? Did it result in an injury? ☐ Yes ☐ No

During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

General Health Status: Please rate your health. ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any known allergies (including medications, latex, etc.) below.

Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.

Name	Dosage	Frequency	Please Indicate Route
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other

Surgery / Hospitalization, Please Include Date and Reason.	

Are you currently experiencing any of the following?

Nausea or Vomiting	☐ Yes ☐ No	Chest Pains (Angina)	☐ Yes ☐ No
Productive/Chronic Cough	☐ Yes ☐ No	Pain Wakes Me at Night	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Recent Fever, Chills, Sweats	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Difficulty Sleeping	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Visual Problems	☐ Yes ☐ No	Heart Palpitations	☐ Yes ☐ No
Hearing Loss/Ringing in Ears	☐ Yes ☐ No	Loss of Appetite	☐ Yes ☐ No
Difficulty Walking	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Unusual Weakness	☐ Yes ☐ No	Fatigue or Myalgia	☐ Yes ☐ No
Joint Pain or Swelling	☐ Yes ☐ No	Unexplained Weight Changes	☐ Yes ☐ No

Social History / Wellness

Do you drink alcoholic beverages? ☐ Yes ☐ No | Do you use tobacco? ☐ Yes ☐ No

How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? ☐ At least 3 times per week ☐ 1-2 times per week ☐ Seldom or Never

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Have you been diagnosed with any of the following?			
Allergies	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Hepatitis, If Yes, Type:	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Respiratory Problems	☐ Yes ☐ No	Kidney Disease/Problems	☐ Yes ☐ No
Auto Immune Disease If yes, Type:	☐ Yes ☐ No	Spinal Cord Stimulator	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Bowel or Bladder Disorder	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Cancer, If yes, Site:	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Cardiac Conditions	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No	Peripheral Vascular Disease	☐ Yes ☐ No
Currently Pregnant	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Speech Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Hearing loss	☐ Yes ☐ No
Stroke/TIA	☐ Yes ☐ No	Fractures	☐ Yes ☐ No

Current Condition
When did this problem(s) first begin/date of onset? If chronic, when did you seek medical treatment?
Is your current condition related to recent surgery? ☐ Yes ☐ No If yes, specify date of surgery?
Describe the problem(s).
Explain how problem(s) occurred.
Have you ever had this problem before? ☐ Yes ☐ No If yes, how many times?
Are your symptoms worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Same All Day
How are you taking care of the problem(s) now?
My pain/problem is getting: ☐ Worse ☐ Better ☐ Staying the Same
My symptoms bother me: ☐ Constantly (100%) ☐ Most of the Time (75%) ☐ Occasionally (50%) ☐ Once in a While (25%)
Do you have any numbness, tingling, or burning? ☐ Yes ☐ No If yes, please check one: ☐ Constantly ☐ Intermittently
What functions could you perform before, that you now are unable to do?
Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.
Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.
Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No If yes, please tell us what it is:
What are your goals for therapy?

I will advise the therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.

Signature:_____ Date: _____