Outpatient Registration Form

Today's Date:	Last Name:	First Name:	Middle Init.	Gender

Maiden Name:	DOB:	Marital Status:	Race/Ethnicity:	Religion:

Social Security #:	Primary Care Physician:	What language do you wish to discuss your healthcare in?

Home Address	Apt #	City	State	Zip Code

Home Telephone #	Cell Phone #	Email Address _____ ☐ Check this box if you DO NOT want to be contacted via email regarding our services.

Employer's Name: _____ *(Please check which applies)* ☐ FT ☐ PT ☐ Unemployed ☐ Retired ☐ Student	Employer's Telephone #

Primary Ins Holder/Sponsor's name and relationship:	Insurance company:
Date of Birth:	Holder/Sponsor's SSN:
Secondary Ins Holder/Sponsor's name and relationship:	Insurance company:
Date of Birth:	Holder/Sponsor's SSN:
Third Ins Holder/Sponsor's name and relationship:	Insurance company:
Date of Birth:	Holder/Sponsor's SSN:

Emergency Contact Name	Relationship	Home Telephone #	Cell Phone #

Emergency Contact Employer's Name	Work Telephone #

A Department of Mary Immaculate Hospital

Clinic Patient ID sticker

InMotion Physical Therapy: Medical History

Clinic Patient ID sticker

Name: _____

Have you had **surgery** for your condition? ◯ **Y** ◯ **N** If yes, please give date(s):_____

Have you had **injections** for your condition? ◯ **Y** ◯ **N** If yes, please give date(s):_____

Please list any **diagnostic tests** you have had for this condition: _____

Have you previously had, or are you currently receiving, any of the following services for your condition?

Physical Therapy, Chiropractic care, Acupuncture, Massage, Personal Training ◯ **Y** ◯ **N**

What are your current symptoms, **including pain location** if applicable? _____

_____

When did the injury or symptoms occur? _____

How did the injury or problem occur? _____

_____

Please rate your pain using a 0-10 scale (0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset _____ **Lowest** pain since onset _____ **Today's** pain _____

Is your pain? ◯ **Constant** ◯ **Intermittent**

What makes your pain/problem **better**? _____ **Worse?** _____

Is there pain present at night? ◯ **Y** ◯ **N** What position helps you sleep? _____

*** What do you hope to accomplish with therapy?** _____

_____

Have you had any recent **falls** (within past 3 months) ◯ **Y** ◯ **N** If yes, when? _____

Do you worry about falling? ◯ **Y** ◯ **N** Do you have dizziness? ◯ **Y** ◯ **N**

What type of **non-work** activities are you involved in? _____

When are you scheduled to see your doctor again? _____

How would you rate your overall health status (circle one) ? ◯ **Poor** ◯ **Fair** ◯ **Good** ◯ **Excellent**

Medical History (please check any of the following that apply):

☐ Unexplained Weight loss > 10lbs recently

☐ Alcohol use	☐ Ehlers-Danlos synd.	☐ HIV/Aids	☐ Pregnant
☐ Arthritis	☐ Epilepsy	☐ High Blood Pressure	☐ Scoliosis
☐ Asthma	☐ Fibromyalgia	☐ Latex Allergy	☐ Stroke
☐ Cancer	☐ Heart Disease/High Chol.	☐ Multiple Sclerosis (MS)	☐ Thyroid Problems
☐ Depression	☐ Hearing Impaired	☐ Osteoporosis	☐ Tobacco Use
☐ Diabetes	☐ Hepatitis	☐ Pacemaker	☐ Tuberculosis

Other: _____

Employment History: Are you currently working? ◯ **Y** ◯ **N** How many total days of work have you missed? _____

Are your work duties ◯ **Restricted** ◯ **Full** How many hours per week do you work? _____

Who is your employer? _____

What type of work do you do? _____

What critical work duties have been most affected by your problem? _____

To the best of my knowledge and belief, the information I have given is complete and true. Please sign below.

**** Patient signature:** _____ **Date:** _____ **Time:** _____

Therapist signature: _____ **Date:** _____ **Time:** _____

A Department of Mary Immaculate Hospital

Personal Representative and Information Form

I,_____, authorize Bon Secours Outpatient Rehabilitation Services to release information about my medical care to:

_____ _____
(Relationship)

_____ _____
(Relationship)

I understand that I must notify Bon Secours Outpatient Rehabilitation Services in writing in order to terminate this designation. I also understand that Bon Secours Outpatient Rehabilitation Services is not responsible for information that is re-disclosed by the above named individual(s).

_____ _____ _____
(Patient's signature) (Date) (Time)

Date of Accident/Incident or Onset of Recent Symptoms	**Type of Incident:** ◯ **Auto** ◯ **Work** ◯ **No Accident** ◯ **Other:** _____

Would you like information in reference to financial assistance? ◯ Yes ◯ No

Do you have transportation issues which may prevent you from attending your therapy? ◯ Yes ◯ No

General Communication Preferences

Please circle your preferred method for communication with our department. If you are not a current MyChart user, please ask our staff for more information. MyChart is our preferred method of communication for appointments and unexpected clinic closures. You can also view your medications, test results, medical bills, price estimates, and more all in one place.

Communication	Mail	Phone	Text Message	Email	MyChart
MyChart Account Management					
Appointments					
Billing					

A Department of Mary Immaculate Hospital

Clinic Patient ID sticker

9-2021

Patient's Responsibilities

Welcome to In Motion Physical Therapy! Thank you for choosing this facility for your rehabilitation.

We look forward to serving you with the highest quality of care available. The following information is to help ensure you, and other patients, have an enjoyable therapy experience.

- If you need to **cancel or reschedule an appointment, please call us at least 24 hours in advance** so that we may open that appointment up to other patients.
- It is important for you to be on time for your appointments. **If you are late, your therapy session may be cut short, or we may have to reschedule your appointment.**
- **If you miss three or more appointments,** you may be **discharged from therapy** services and your physician will be notified.
- If you **no-show for 2 appointments in a row** and cannot be reached to reschedule, **we will remove you from the schedule**.
- **Worker's Compensation patients—**all cancellations and no-shows will be documented and your adjuster/case manager and employer will be notified.
- Your therapist will give you some instructions/exercises for home. **It is important that you follow these instructions to achieve the maximum benefit from therapy.** Your family should be involved in your care if you require assistance at home.
- Periodically and upon completion of your therapy, we will send progress notes to your physician with recommendations. Together, your therapist, your physician and you will decide when you have reached the maximum benefit from your rehabilitation. **Remember: Simply because your physician writes you a prescription for therapy does not guarantee payment from your insurance company.** We must show objective and functional improvement in an appropriate time frame; otherwise, we are mandated to discharge you from therapy.
- Therapy is performed in an open gym setting. Your therapist may use a curtained treatment area or a private treatment room if increased privacy is necessary.
- Please notify your therapist, the front office or another staff member if you are dissatisfied with your level of care so that we may remedy the situation.
- Out of respect for your privacy and that of other patients, please refrain from using your cell phone during your visit.

Thank you for giving us the opportunity to serve your rehab needs. We look forward to helping you achieve your goals and providing you excellent care.

Patient Signature Date Time