Bon Secours Physical Therapy
Medical History / Subjective Information

Name: _____ **Age:** _____

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 had any **previous Physical Therapy or Chiropractic treatment** for this condition? **Y** **N**

What are your current symptoms? _____

Where is your pain or problem located? _____

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 are your goals?"** _____

Therapist's comments: _____

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

Do you worry about falling? **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**

Would you like to speak with someone regarding **abuse or neglect** that you have recently experienced? **Y** **N**

Would you like to speak with someone regarding **suicide**' **Y** **N**

I consent to be treated in an open gymnasium atmosphere: **Y** **N**

If you marked "YES" - if at any time during the course of your therapy you would prefer to be treated in a private area, please tell your therapist, and they will make appropriate accomodations.

Employment History Are you currently working? **Y** **N** If no, 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:** _____ ******

Therapist's comments: _____

Therapist's signature: _____ **Date:** _____ **Time:** _____

Outpatient Registration Form

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

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

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

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

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 ☐	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 #

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

Advanced Directive Information:
Written Living Will for Medical Choices: Y N if yes, location: _____

Written Medical Power of Attorney: Y N if yes, name and location: _____

Patient Name: _____ **DOB:** _____

Patient Summary List

Are you allergic to latex? YES NO

Do you have any known allergies? (drug or other) YES NO **if YES**, please list below:

Allergies or Drug Allergies	Reaction/Symptoms when allergy occurs	For Clinician Use Only If new, initial and date

☐ Check this box if you have brought a listing of your current medications and you will not have to complete the medication list below. Please give your list to our office staff to include in your chart.

☐ Check this box if you are NOT currently taking any medications.

Current Medication List (include OTC and herbal)	Dosage	Frequency	For Clinician Use Only New	D/C	Date/Initials

Medical History (check all that apply)

	Heart Disease		Diabetes		Weight change of more than 10 lbs recently		
	Fibromyalgia		Tuberculosis		High Blood Pressure		Asthma
	HIV/AIDS		Arthritis		Visual Impaired		Epilepsy
	Depression		Pacemaker		Hearing Impaired		Cancer
	Osteoporosis		Thyroid Problems		Latex Allergy		Scoliosis
	Ehlers-Danlos synd.		Alcohol Use		Pregnant		Stroke
	Multiple Sclerosis (MS)		Other (please explain):		Tobacco Use		Hepatitis

Additional/New Medical History	If new, Clinician Initial/Date	Surgical/Invasive Procedure History	Date of Procedure	If new, Clinician Initial/Date

**** Patient Signature:** _____ **Date:** _____ **Time:** _____

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

PATIENT'S RESPONSIBIILITIES FOR OUTPATIENT PHYSICAL THERAPY

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 3 appointments or more**, you may be **discharged from therapy** services and your physician will be notified.
- If you complete your treatment with us with a good attendance record, you will receive a gift upon discharge.
- 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, 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 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.
- For safety reasons, children are not permitted in the treatment area.

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

Bon Secours Physical Therapy & Sports Medicine

Personal Representative/Medical Records Request

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)

Patient Contact Request

I wish to be contacted in the following manner (check all that apply):

Home Telephone_____
Leave message with detailed information
Leave message with call back # only

Work Telephone_____
Leave message with detailed information
Leave message with call back # only

E-**mail** _____

Written Communication
Okay to mail to home address
Okay to mail to work/office address

Other: _____
_____
_____