PATIENT REGISTRATION FORM

(Kindly print)

Name: ___________________________________ Date:_________

First *Middle* *Last*

Address**:** ________________________________

____

____

Home #:________________ Work #:______________ Cell #:_____________

Email: _____________________________________

Date of Birth: ____________ Sex: ____ Marital Status: ________

Social Security#_____________________ Age: _______

Emergency Contact's name and phone: ____

Can we release medical info to this person? Y N

Referring Physician/Person: ____________________________

Primary Care Physician: ___________________ Phone#________________

Have you received physical therapy this year? Y N

If yes, at what facility and for approximately how long? ________________________

Does the patient live at the primary insured address Y N

If No, please provide address and phone #of primary insured:

____

____

______________________________________ Phone#________________________

Insurance information:

Primary insurance: _______________________ ID and Group #:_______________

Subscriber (Patient/Guardian): ___________________ Relationship: _________________

Subscriber's DOB: ______________ Subscriber's SS# *(required)* _____________

Secondary insurance: ____________________ ID and Group #:_______________

Subscriber: ___________________ Relationship: _________________

Subscriber's DOB: ______________ Subscriber's SS# *(required)* _____________

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<u>If this is due to a work related injury, please complete the following:</u>

Employer: _______________________________ Date of accident: _________

Employer address: ____

Claim #____________________________

Case Manager/contact person: ___________________________ Phone#_________

<u>If this is due to a Motor Vehicle Accident, please complete the following</u>:

Insurance company: ________________________ Claim#: _______________

Insurance address: _________________________ Phone#_______________

Case Manager/Contact Person: ___________________ Date of accident: _________

Attorney *(if applicable)*:_________________________ Phone#__________________

Are you receiving Chiropractic Care Y / N

If you are receiving Chiropractic care please schedule your physical therapy appointments on separate days. Motor Vehicle insurance does NOT allow for a person to have Chiropractic and Physical Therapy services on the same day. Thank You

CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

Insurance Customers:

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist, and/or physician may be considered necessary or advisable while a patient at Joint Motion, L.L.C. Physical Therapy. I consent to the use of my otherwise protected health information for my treatment, Joint Motion practice operations, and to secure insurance reimbursement. I understand that I will be treated in an open air environment and limited personal information may be unavoidable disclosed. I request that payment of authorized benefits be made on my behalf to:
Joint Motion, L.L.C.
373 Park Ave
Scotch Plains, NJ 07076
For any services furnished me by Joint Motion, L.L.C. Physical Therapy. I authorize any holder of medical information about me to release to my insurance company(ies) and its agents any benefits payable for related services. I hereby authorize my insurance company(ies) to furnish to the above named therapist any information regarding my insurance claims under Title XVIII of the Social Security Act. I also am aware that I may be responsible for any charges that my insurance company denies payment for service as "not medically necessary."
A copy of this signature is as valid as the original.

Signature (Patient/Guardian): ______________________________

Witness (Joint Motion Staff): ______________________________ Date: __________

Self Pay Customers only:

Name of Patient: ____

This is to certify that I am financially responsible to Joint Motion, LLC for services rendered to me. I also authorize payment directly to Joint Motion, L.L.C. benefits otherwise payable to me but that do not exceed the charges stated.
Per Visit Charge: $_____________ initial_____

Signature (Patient/Guardian): ______________________________

Witness (Joint Motion Staff): ______________________________ Date: __________

ACKNOWLEDGEMENT OF RECEIPT OR PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our Notice and ask questions about our privacy practices. The terms of our notice may change. Upon request a copy of our revised notice will be made available to you.

By signing this form you acknowledge that you have received our Notice of Privacy Practices.

____

Name of Patient

____

Signature of Patient/Guardian

NOTIFICATION OF APPOINTMENT ALERT SYSTEM

Our office utilizes both a text or voice alert system to notify you of upcoming appointment dates and times. Medical information specific to your care and treatment will <u>not</u> be shared via the automatic alert system. Unless you choose differently below, the default selection is via text alert to your mobile phone number. You may opt of this alert system at any time. If you choose to do so, please notify our front office personnel either verbally or in written form at your earliest convenience.

Please select your preference:

- ☐ I prefer a Text Alert only: (Cell number will be default) preferred phone if other #________________
- ☐ I prefer a Voice Alert to phone number :__________________ only
- ☐ I prefer to opt out and not receive an alert.

* Please review our cancellation/no show policy. Note, we reserve the right to charge a fee for appointments cancelled/missed without 24 hours prior notification.

** To ensure that we provide you with the best care possible, <u>within a 1 week notice</u>, kindly provide our office staff with your future doctor's appointment information. In doing so, this will help maintain good communication between our office and your medical providers.

By signing this form you acknowledge that you have read our Appointment Alert System Notice

____

Name of Patient

____

Signature of Patient/Guardian

<u>"We DO MORE of what we love…so you can DO MORE of what you love."</u>

MEDICAL SCREEN FORM

Name:			Date of Birth:	
Height (in inches):	Weight:	Age:	Gender: **M / F**	Smoker: **Y/N**
Are you pregnant(Females): **Y/N**	Occupation:		Work status: Full/Modified/Not Working	

PAST MEDICAL HISTORY Have you or a family member EVER been told that you have or had:

You Family ↓ ↓	You Family ↓ ↓	You Family ↓ ↓	You Family ↓ ↓
❑ ❑ Allergies/Asthma	❑ ❑ Heart Disease	❑ ❑Mental Illness	❑ ❑Sexually Transmitted Dis.
❑ ❑ Angina/Chest Pain	❑ ❑High Blood Pressure	❑ ❑ Neurological Disease	❑ ❑ Stroke/TIA
❑ ❑ Blood Clot/DVT	❑ ❑High Cholesterol	❑ ❑ Osteoarthritis	❑ ❑ Ulcers
❑ ❑ Cancer(specify below)	❑ ❑Kidney Disease	❑ ❑ Osteoporosis	❑ ❑ HIV/AIDS
❑ ❑ Diabetes	❑ ❑Liver Disease	❑ ❑ Rheumatoid Arthritis	❑ ❑Autoimmune Disease
❑ ❑ Fibromyalgia	❑ ❑Lung Disease	❑ ❑ Seizure/Epilepsy	❑ ❑ Allergies-Pets
OTHER:			

Have you had a recent illness or infection? ☐ YES ☐ NO If yes please explain___________________________________
Do you take blood thinners? ☐ YES ☐ NO
Are you allergic to latex or adhesives? ☐ YES ☐ NO
During the past month, have you been bothered by feeling down, depressed or hopeless? ☐ YES ☐ NO
During the past month, have you been bothered by little interest or pleasure in doing things? ☐ YES ☐ NO If yes, Is this something in which you would like help? ☐ YES ☐NO ☐ Yes but not today
Has your weight changed significantly since your symptoms began? ☐ YES, unsure why ☐ YES, I know why ☐ No
In the past 12 months, have you fallen? ☐ YES ☐NO If yes, how many times? ____ Did it cause an injury? ☐ YES ☐NO
Have you had any problems with bowel or bladder functioning (incontinence, etc) ☐ YES ☐ NO

PAST RELEVANT or RECENT SURGICAL HISTORY

Surgery: ____ Date: ______________

Surgery: ____ Date: ______________

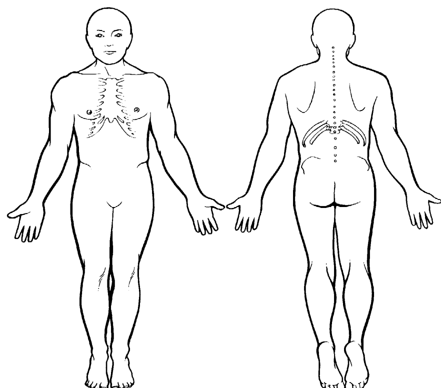
MEDICATIONS (Name, Dosage and Frequency)
☐ see attached list (please provide a list if checking this line)

CURRENT SYMPTOMS
Where are you currently having symptoms? **Body Region(s)** : ☐Right ☐Left ☐ Both
What date (approximately) did your present pain start?
How did it begin? (gradually, suddenly, injury)
My symptoms are currently (circle one): GETTING BETTER ABOUT THE SAME GETTING WORSE
Have you received any type of treatment for this problem (Injections, PT, Chiropractic, Acupuncture, Etc)? ☐ YES ☐ NO
Have you ever had this problem before? ☐ YES ☐ NO
If yes, how was the problem treated?

MEDICAL SCREEN FORM

How long did it take you to feel better?
For your current problem, have you had an x-ray, MRI, or other imaging study? **Y/N**, if yes, which& results?
How are you able to sleep at night? (circle one) WELL MODERATE DIFFICULTY ONLY WITH MEDICATION
Does coughing, sneezing or taking a breath make your symptoms worse? ☐ YES ☐ NO
Does eating certain foods change your symptoms? ☐ YES ☐ NO
Have you recently experienced (Please circle any that apply) :Nausea/Vomiting/Fever/Chills/Sweats/Extreme Fatigue ☐ YES ☐ NO
What makes your symptoms better?
Please circle the activities that make your pain worse: Lying Down Sitting Standing from a sitting position Prolonged Standing Lifting Gripping Walking Stress Reaching Stairs Other:____
Please list the best and worst time of day for your symptoms BEST_______________ WORST_____________________
What is your personal goal for therapy?

BODY CHART: Please mark the areas where you feel pain on the chart below



For the therapist
+ / - Cough/Sneeze
+ / - Saddle Anesth.
+ / - Bwl/Blddr Chnge
+ / - Numb/Ting.

On the scales below, please circle the number which best represents the severity of your pain in general:

Average for the last 48 hours: 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Best for the last 48 hours: 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Worst for the last 48 hours: 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Please circle the number below which best represents your overall average level of function.

0 (Cannot do anything) 1 2 3 4 5 6 7 8 9 10 (Able to do everything)

<u>Aggravating Factors</u>: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1)____

2)____

3)____

Below for therapist :
Rating: _____
Rating: _____
Rating: _____

For Therapist Use *Patient Specific Functional Scale Avg:* _____________

Score for SPPB/ QDASH/ LEFS/ NDI/ODI/BERG : _____________

<u>CONSENT</u>: I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

Signature____Date_____________ Therapist initials__________