GLO PHYSICAL THERAPY
GREAT LAKES ORTHO PHYSICAL THERAPY

REGISTRATION FORM

Name:_____ Date:_____
Age: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone(Home/Cell) _____ Email: _____
How did you find us? _____

Emergency Contact Informatiion:
Name:_____ Phone Number:_____
Relationship to Patient: _____

Employer Information:
Employer Name: _____ Occupation: _____
Employer phone number: _____ Are you currently working? ☐ Yes ☐No

Physician Information:
Name of Physician: _____ Physician Phone: _____
Physician Address: _____

Health Insurance Information:
Primary Insurer: _____ ID# _____ Group# _____
Policy Holder Name: _____ Date of birth _____
Relationship to the Policy Holder: _____ Policy Holder Social Security# _____
Secondary Insurer: _____ ID# _____ Group#_____
Relationship to the policy Holder: _____ Policy Holder Social Security#_____

Is this an **Auto Accident?** ☐ Yes ☐ No Date of Injury _____ Is this a lawsuit? ☐Yes ☐No
Name of Attorney/FIrm: _____
Attorney Phone: _____

Is this an **Approved Workers Comp Injury?** ☐Yes ☐ No Date of Injury_____
Job Tittle
Name of Attorney/FIrm Case Worker: _____ Phone: _____

CONSENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

Consent to Treat: I request and give consent to Great Lakes Physical Therapy (GLPT) to provide and perform procedures and other services as considered necessary or beneficial by GLPT for my health and well being. I acknowledge that no warranties or guarantees as to the results have been made to me or relied upon me. I understand that a physical therapy diagnosis is not a medical diagnosis by a physician. I understand that it is my responsibility to inform GLPT if I experience any discomfort or pain during any treatment or if I have other unresolved concerns around my treatment. I understand that response to therapy intervention varies from person to person and it is possible that treatment may result in aggravation of existing symptoms or may cause pain or injury.
Initials: _____

WORKERS COMPENSATION PATIENTS: I understand that Great Lakes Physical Therapy is required to inform my Worker's Compensation Adjuster and/ or Rehabilitation Manager of all missed or canceled appointments. I understand that any missed visits must be rescheduled.
Initials: _____

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APPOINTMENT ATTENDANCE AGREEMENT: I understand the importance of attending therapy consistently, scheduling appointments in advance and arriving promptly for my appointment. I agree to provide at least 24 hours'notice when I need to cancel or reschedule an appointment. ***I understand that cancellation of, or failing to keep an appointment with less than 24 hours' notice will result in a cancellation fee of $35 or a no show fee of $50.***
Initials:

FINANCIAL AGREEMENT: All co-payments/fees for self- pay services are due at the time of service. I acknowledge that, in consideration of the services provided to me by Great Lakes Physical Therapy (GLPT), I am financially responsible for payment of my bill. I hereby assign Great Lakes Physical Therapy (GLPT) all my rights and claims for reimbursement under my health insurance policy. I acknowledge that it is my responsibility to provide GLPT with my insurance information, and to familiarize myself with my insurance plan/policies. Any questions I have regarding my insurance coverage or benefit levels should be directed to my insurance provider. My insurance plan may stipulate that all or a portion of the charges/balance (such as deductible/co-payment/co-insurance or other charges not covered or otherwise denied by my insurance plan or carrier, Medicare, or any other health insurance programs for which I am eligible) remain my personal responsibility, and I agree to pay any such charges. I understand that GLPT will bill my insurance carrier as a courtesy, but that I am ultimately responsible for any payments owed. If I pay any amount via check, I hereby authorize GLPT to use the information from the check to process a one-time Electronic Funds Transfer (EFT/ACH) or a draft drawn from my account. I understand that if my payment is processed as an EFT/ACH, funds may be withdrawn from my account as soon as the same day, and my check will not be returned by my financial institution. If formal collection procedures become necessary, I am responsible for any additional costs incurred as a result of such procedures. I agree that, in order for GLPT to collect any amounts I may owe, I may be contacted by GLPT and its affiliates via any telephone number associated with my account, including wireless telephone numbers, which could result in additional charges. I understand that I may also be contacted via text message or email, using any email address I have provided to GLPT. Methods of contact may include pre-recorded/artificial voice message and use of automated dialing devices as applicable.

PLEASE NOTE: Refusal to sign this form does not alter responsibility for payment in any way.
Initials: _____

ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that Great Lakes Physical Therapy (GLPT) may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize GLPT to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that have received GLPT Notice of Privacy Practices and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information.

I acknowledge that I have received GLPT Notice of Privacy Practices and that it outünes how my personal health information may be disclosed and utilized, and how I may gain access to and control my personal health information.
Initials: _____

I consent to disclose my PersonaL Health Information to the following family members or friends:

_____ _____

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document, and sign below freely and voluntarily.

Printed Name of Patient _____

Signature of Patient/ Legally Responsible Person _____ Date _____

Printed Name of above (if not the Patient) _____ Date _____

MEDICAL HISTORY FORM

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Name: _____ Date: _____

Date of Birth: _____ Age _____ Height: _____ Weight: _____

Gender: _____ Pacemaker: ☐ YES ☐ NO Do You Smoke? ☐ YES ☐ NO Packs Per Day: _____

Allergies?_____ Are you on **WORK RESTRICTION** from your doctor: ☐ YES ☐ NO

Current Complaint: _____ When did symptoms start? _____

How did symptoms start? _____

_____

My Symptoms are currently (Circle One): Getting Better Getting Worse Staying the same

Treatment received so far for this issue (chiropractic, injections, PT, etc.):_____

_____ Did previous treatments help? ☐ YES ☐ NO

Please list any special tests performed for this problem (X-Ray, MRI, Labs, etc.):_____

_____

Findings: _____

PLEASE LIST PAST SURGICAL/HOSPITALIZATION HISTORY WITH DATES: _____

_____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING (Circle all that apply)?

Cancer	Liver Issues	High Blood Pressure	Osteoporosis	Blood Clots
Asthma	Heart Condition	Sexually Transmitted Disease	Bone/Joint Infection	Depression
Anemia	High Blood Pressure	Bladder/Urinary Tract Infection	Kidney Issues	Pneumonia
Stroke	Multiple Sclerosis	Pelvic Inflammatory Disease	Circulation Issues	Diabetes
Epilepsy	Eye Issues/Infection	Rheumatoid Arthritis	Tuberculosis	Lung Issues
Ulcers	Alcoholism	Other Arthritic Condition	Other: _____	

CURRENTLY, I AM EXPERIENCING (Circle all that apply):

Fever/Chills/Sweats	Difficulty Swallowing	Recent Weight Gain	Difficulty Urinating
Changes in Appetite	Shortness of Breath	Headaches/Migraines	Muscle Weakness
Unexplained Weight Loss	Pain With Intercourse	Poor Balance/Falls	Malaise
Bowel/Bladder Issues	Numbness/ Tingling	Lightheadedness	Cough
Increased Pain at Night	Constipation/Diarrhea	Nausea/ Vomiting	Fatigue

Other: _____

During the past month, have you felt down, depressed, or hopeless? ☐ YES ☐ NO

During the past month, has it been difficult to find interest or joy in doing things? ☐ YES ☐ NO

Is this an area in which you would like help? ☐ YES ☐ NO

FALL RISK ASSESSMENT

Do you experience dizziness or vertigo? ☐ YES ☐ NO Do you need help standing or walking? ☐ YES ☐ NO

Have you fallen in the last 30 days? ☐ YES ☐ NO

MEDICAL HISTORY FORM - CONTINUED

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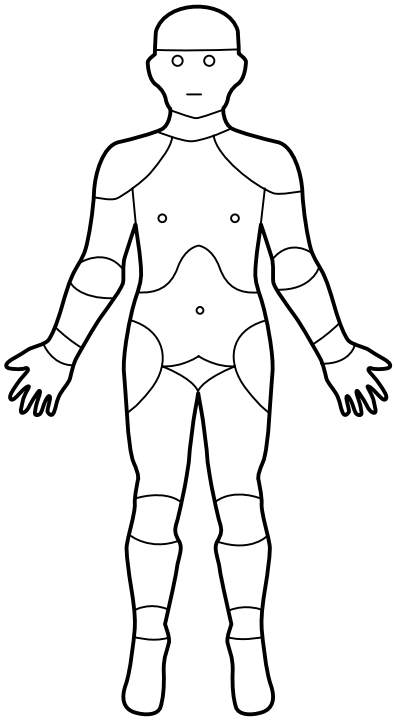
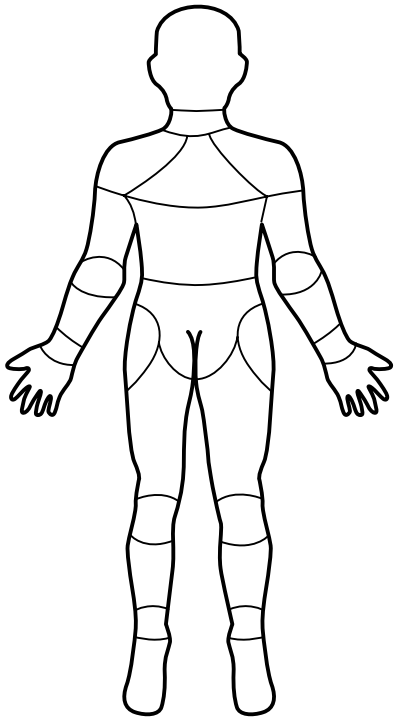
LIST OF **MEDICATIONS** YOU ARE CURRENTLY TAKING (Including pills, injections, supplements, and skin patches):

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Where is your pain? Mark the figures using the key. KEY: 00 = Pain II = Numbness XX = Tingling





TYPE OF PAIN (Circle all that apply): Aching Throbbing Sharp Burning Numb Tingling Shooting

Other: _____

DURATION OF PAIN (Circle): Constant Most of the Time Comes and Goes Once in Awhile Hardly Ever

PAIN INTENSITY - Rate your pain on a **0-10** scale, with a **0** for **NO PAIN** and **10** for the **WORST PAIN IMAGINABLE:**

Average level of pain during the **last 24 hours:** **Lowest** pain: **Highest** pain:

What activities/position increase your pain? _____

What activities/position decrease your pain? _____

What activities/movements are hindered by your pain? _____

What are your goals for Physical Therapy? _____

SOCIAL/LEISURE/EXERCISE HISTORY

Living Arrangement (Circle One): House Condo/Apartment Group Residence Nursing Home

Other: _____ Do you live alone? ☐ YES ☐ NO

What is your **activity level**? Sedentary Light Activity Moderate Activity Very Active Extremely Active

How many days a week do you perform **a regular fitness routine**? _____