Registration Form

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Patient Information (Please Print) Today's Date:____________________

Patient Legal Name: ____
Last First MI

DOB:____/_____/_______ Social Security Number: _______-_______-__________ Sex: ________

Street Address: ________________________ City: _________________ State: _______ Zip:________

Employer: _____________________________ Occupation: ____________________________

Home/Cell: (_____)_______________ Work Phone:(_____)_______________ Email:________________

Referring Physician: ______________________ Phone: (____)__________________

Insurance Information (Please Complete)

Person Responsible for bill: _____________________________ DOB: ____/____/_______

Address (if different): _______________________________________ Primary Phone (____)___________

Relationship to Patient: ▢Self ▢Spouse ▢Child ▢Other:_______________________

Is this patient covered by insurance? ▢Yes ▢No

Primary Insurance:________________________ Subscriber's Name:_________________________

Subscriber's SSN:_____-_____-______ DOB:___/___/______ Policy #:________________ Group #________

Patient's relationship to subscriber: ▢Self ▢Spouse ▢Child ▢Other:_______________________

Secondary Insurance:______________________ Subscriber's Name:_______________________

Subscriber's SSN:_____-_____-______ DOB:___/___/______ Policy #:________________ Group #________

Patient's relationship to subscriber: ▢Self ▢Spouse ▢Child ▢Other:_______________________

In case of emergency

Name of friend or relative:____________________ Relationship to Patient:__________________

Primary Phone:(____)________________ Secondary Phone: (____)_____________________

Patient Medical History

Name: ______________________________ Date:__________________

Reason for visit/Chief Complaint:____

Height:_____________ Weight:___________

Medical Conditions

Please check off any medical conditions that you have a history of:

▢ Hypertension
▢ Diabetes
▢ Cardiovascular disease
▢ Stroke
▢ Depression
▢Other:___________________________
▢ Asthma
▢ High Cholesterol
▢ Cancer
▢ HIV/AIDS
▢ Previous falls

Do you currently smoke tobacco? Y N If yes, how often?___________

Have you been offered smoking cessation? Y N

Current Medications

Please list all medications you are currently taking (include vitamins, supplements, aspirin, etc.)

Name of Medication and strength: How often?

___________________________ ▢Daily ▢Weekly ▢Monthly ▢As needed ▢Other:___________

___________________________ ▢Daily ▢Weekly ▢Monthly ▢As needed ▢Other:___________

___________________________ ▢Daily ▢Weekly ▢Monthly ▢As needed ▢Other:___________

___________________________ ▢Daily ▢Weekly ▢Monthly ▢As needed ▢Other:___________

Surgical History: (Include C-Sections, tonsillectomy, gallbladder, oral, etc.)

Date of Surgery: Type of Surgery:

__________________ ____

__________________ ____

__________________ ____

Informed consent for Physical Therapy Care

Physical therapy is the evaluation or treatment of a person by the use of the effective properties of physical measures and heat, cold, light, water, electricity, sound, and air; and the use of therapeutic massage, therapeutic exercise, mobilization, and the rehabilitation procedures with or without of assistive devices for the purposes of preventing, correcting, or alleviating a physical or mental disability, or promoting physical fitness.

Patient Rights

- All persons who seek physical therapy care have the right to service regardless of age, gender, race, nationality, religion or politics.
- Clients have the right to refuse physical therapy services.
- Clients have the right to privacy, confidentiality, self-determination including participation in decisions made about care, cease therapy, and access to second opinion.
- Expect that the physical therapist shall provide consultation, evaluation, treatment, and preventative care in accordance with the laws and regulations of Georgia.

Patient Responsibilities

- Provide your clinician complete and accurate health and insurance information concerning illness, hospitalizations, allergies and function.
- Request additional information when you do not understand.
- Inform your clinician if you anticipate problems complying with the treatment plan
- Demonstrate respect and consideration for other patients, and facility staff
- Notify your clinician of any changes in your condition

I hereby request and consent to the performance of physical therapy procedures. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read the above consent. I have also had the opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: ____ **Date:**________________________

(or signature of Legal Guardian)

HIPAA Privacy Compliance

Acknowledgement of Receipt of Notice and Privacy Practices

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA's Privacy Rule requires that providers with a direct treatment relationship make a good faith effort to obtain an individual's written acknowledgement of receipt of the Notice of Privacy Practices.

Privacy Standard/Rule (HIPAA)

The Privacy Rule sets the standards for how protected health information (PHI) "in any form or medium" should be controlled. This Rule took effect in April, 2003 for large entities, and a year later for small ones.

Privacy Rule protections extend to every patient whose information is collected, used or disclosed by covered entities. It imposes responsibilities on the entire work force of a covered entity -- including all employees and volunteers -- in order to secure those rights. It also requires contractual assurances for any business associates of health care institutions that handle health care information on a covered entity's behalf.

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. It explains how we may use it for the purpose of treatment, payment of treatment, and as required/permitted by law. The notice may be subject to change or revision. If changes or any revisions are made to this notice, you may obtain a revised notice by request.

By signing below, you acknowledge that you were provided a copy of the notice upon request on the date indicated below.

Patient Name: ____

Patient/Responsible Party Signature: ____

Date: ______________________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Employee Signature: ___________________________________ Date: ______________________

Cancelation / No-show Policy

Dear Patient,

We understand that periodically you may have to cancel or reschedule your appointment. In the event that you are unable to make your scheduled appointment, please contact our office as soon as possible to reschedule or to cancel. It is likely that another patient is waiting for a cancellation in order to receive treatment; therefore, please try to give us 24 hours notice if you are unable to make your appointment.

Three or more cancellations without a 24 hour notice and/or "no-shows" in a one month period will result in a charge to your account of **$25.00.**

______________________________ ______________________

Patient Name DOB

______________________________ ______________________

Patient/Guardian Signature Date

____

Name if signing on behalf of patient

Patient Name

Patient ID #

Date:

Lawton-Brody Instrumental Activities of Daily Living Scale (I.A.D.L.)

Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).

A.Ability to Use Telephone		**E.Laundry**	
1.Operates telephone on own initiative-looks up and dials numbers,etc. 2.Dials a few well-known numbers 3.Answers telephone but does not dial 4.Does not use telephone at all	1 1 1 0	1.Does personal laundry completely 2.Launders small items-rinses stockings,etc. 3.All laundry must be done by others	1 1 0
B. Shopping		**F. Mode of Transportation**	
1.Takes care of all shopping needs independently 2.Shops independently for small purchases 3.Needs to be accompanied on any shopping trip 4.Completely unable to shop	1 0 0 0	1.Travels independently on public transportation or drives own car 2.Arranges own travel via taxi,but does not otherwise use public transportation 3.Travels on public transportation when accompanied by another. 4.Travel limited to taxi or automobile with assistance of another. 5.Does not travel at all	1 1 1 0 0

C.Food Preparation		**G.Responsibility for Own Medication**	
1.Plans,prepares and serves adequate meals independently 2.Prepares adequate meals if supplied with ingredients 3.Heats, serves and prepares meals, or prepares meals but does not maintain adequate diet 4.Needs to have meals prepared and served.	1 0 0 0	1.Is responsible for taking medications in correct dosages at correct time 2.Takes responsibility if medication is prepared in advance in separate dosage 3.Is not capable of dispensing own medication	1 0 0
D.Housekeeping		**H.Ability to Handle Finances**	
1.Maintains house alone or with occasional assistance (e.g. "heavy work domestic help") 2.Performs light daily tasks such as dish washing, bed making 3.Performs light daily tasks but cannot maintain an acceptable level of cleanliness. 4.Needs help with all home maintenance tasks 5.Does not participate in any housekeeping tasks.	1 1 1 1 0	1.Manages financial matters independently (budgets, writes checks,pays rent, bills,goes to the bank),collects and keeps track of income. 2.Manages day-to-day purchases,but needs help with banking, major purchases,etc. 3.Incapable of handling money	1 1 0
Score		**Score**	

Total Score **A summary score ranges from 0 (low function,dependent) to 8 (high function, independent) for women and 0 through 5 for men to avoid potential gender bias.**	

BECK'S DEPRESSION INVENTORY

Instructions: Please circle the number by the response for each question that best describes how you have felt during the past seven (7) days. Please do not omit any questions. Make sure you check one answer for each question. If more than one answer applies to how you have been feeling, check the higher number. If in doubt, make your best guess

1. 0I do not feel sad.
   1 I feel sad
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad and unhappy that I can't stand it.

---

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel the future is hopeless and that things cannot improve.

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3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

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4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

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5. 0 I don't feel particularly guilty
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

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6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

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7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

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8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

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9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

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10. 0 I don't cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated by things than I ever was.
    1 I am slightly more irritated now than usual.
    2 I am quite annoyed or irritated a good deal of the time.
    3 I feel irritated all the time.

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12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

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13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions more than I used to.
    3 I can't make decisions at all anymore.

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14. 0 I don't feel that I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel there are permanent changes in my appearance that make me look unattractive
    3 I believe that I look ugly.

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15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I can't do any work at all.

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16. 0 I can sleep as well as usual.
    1 I don't sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

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17. 0 I don't get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

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18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

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19. 0 I haven't lost much weight, if any, lately.
    1 I have lost more than five pounds.
    2 I have lost more than ten pounds.
    3 I have lost more than fifteen pounds.

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20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
    2 I am very worried about physical problems and it's hard to think of much else.
    3 I am so worried about my physical problems that I cannot think of anything else.

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21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I have almost no interest in sex.
    3 I have lost interest in sex completely

HWALEK-SENGSTOCK ELDER ABUSE SCREENING TEST (H-S/EAST)

Purpose: Screening device useful to service providers interested in identifying people at high risk of the need for protective services. REQUIRED BY MEDICARE

Instructions: Read the questions and circle the answers.

1. Do you have anyone who spends time with you, taking you shopping or to the doctor?	▢Yes ▢No
2. Are you helping to support someone?	▢Yes ▢No
3. Are you sad or lonely often?	▢Yes ▢No
4. Who makes decisions about your life—like how you should live or where you should live?	▢Myself ▢Someone else
5. Do you feel uncomfortable with anyone in your family?	▢Yes ▢No
6. Can you take your own medication and get around by yourself?	▢Yes ▢No
7. Do you feel that nobody wants you around?	▢Yes ▢No
8. Does anyone in your family drink a lot?	▢Yes ▢No
9. Does someone in your family make you stay in bed or tell you you're sick when you know you're not?	▢Yes ▢No
10. Has anyone forced you to do things you didn't want to do?	▢Yes ▢No
11. Has anyone taken things that belong to you without your O.K.?	▢Yes ▢No
12. Do you trust most of the people in your family?	▢Yes ▢No
13. Does anyone tell you that you give them too much trouble?	▢Yes ▢No
14. Do you have enough privacy at home?	▢Yes ▢No
15. Has anyone close to you tried to hurt you or harm you recently?	▢Yes ▢No

Therapist instructions: A response of "no" to items 1, 6, 12, and 14; a response of "someone else to item 4; and a response of "yes" to all others are scored in the "abused" direction

Pain Diagram and Pain Rating

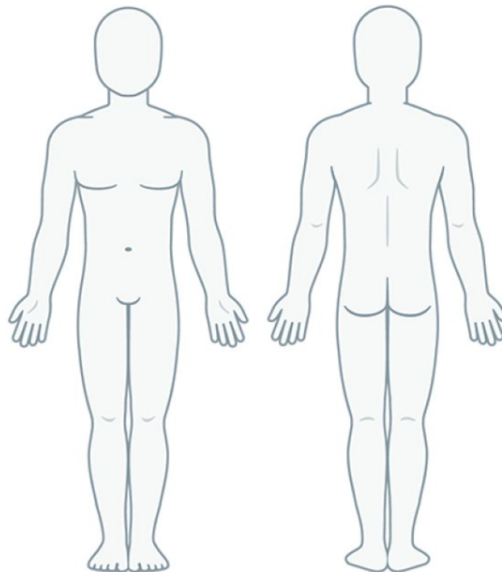
Name:__________________________________ Date:__________________

Instructions: Please use the diagram below to indicate the symptoms you have experienced with your pain.

Which of the following describes your pain? ▢ Aching ▢ Burning ▢ Stabbing

▢ Other __________________________

Please indicate on the diagram below the location of your pain.



0=NO PAIN **10=WORST PAIN IMAGINABLE**

Please rate your **CURRENT** level of pain on the following scale (circle one):

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain at its **WORST** on the following scale (circle one):

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain at its **BEST** on the following scale (circle one):

0 1 2 3 4 5 6 7 8 9 10