FOOTHILLS
SPORTS MEDICINE
PHYSICAL THERAPY

PATIENT REGISTRATION FORM

Please Print

Patient Name:_____ Gender: ☐ Male ☐ Female

Birth Date:_____ Age:_____ Social Security #:_____

Address:_____ City, State, Zip:_____

Home Phone #:_____ Cell Phone #:_____

Email:_____

If under 18, Parent/Guardian:_____ Relationship to Patient:_____

Parent/Guardian Social #:_____ Parent/Guardian Birth Date:_____

Would you like to receive appointment reminders via: ☐ Email ☐ Text (must select provider below)

ALLTel	Cricket Wireless	Quest	Verizon
AT&T	Metrocell	Sprint PCS	Virgin Mobile
Boost Mobile	MetroPCS	T-Mobile	
Cingular	Nextel	US Cellular	

Emergency Contact:_____ Relationship/Phone:_____

Do you have a prescription from a physician or provider for physical therapy? ☐ Yes ☐ No

If yes, who is the referring physician?_____ Return to Doctor Date?_____

How did you hear of Foothills Sports Medicine Physical Therapy?

☐ Friend/Family/Acquaintance	☐ Free Injury Screening	☐ Location/Signage
☐ Former Patient	☐ Foothills Employee	☐ Advertisement
☐ Website/Social Media	☐ Insurance Company/Employer	☐ None, Physician Referred
☐ FAST Client	☐ Sports Club/Coach	

Are you seeking Physical Therapy because of a sports injury through a school or club sport? ☐ Yes ☐ No

School/Team Name:_____

Are you seeking Physical Therapy because of a Work-Related Accident? ☐ Yes ☐ No

Employer Name:_____ Phone:_____

Employer Address:_____

INSURANCE INFORMATION *(To be completed even if insurance card on file)*

Primary Insurance	**Secondary Insurance**
Insurance Co Name:_____	Insurance Co Name:_____
Policy Holder:_____	Policy Holder:_____
Policy Holder Birth Date:_____	Policy Holder Birth Date:_____
Relationship to Patient:_____	Relationship to Patient:_____

Patient/Guardian Signature:_____ Date:_____

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PATIENT INFORMATION AND CONSENT FORM

CONSENT FOR CARE AND TREATMENT: I hereby agree and give my consent to Foothills Sports Medicine Physical Therapy to furnish appropriate rehabilitative care and treatment, as considered necessary and in the best interest in order to attend to the physical condition. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters.

NOTICE OF PATIENT INFORMATION PRACTICES: I have read and fully understand Foothills Sports Medicine Physical Therapy's Notice of Information Practices.

AUTHORIZATION TO RELEASE PATIENT INFORMATION: I hereby authorize Foothills Sports Medicine Physical Therapy to release any protected health information (PHI) required in the course of my examination or treatment to the insurance company, or their affiliates, of which I provided the information.

I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

HIPAA CONSENTS: In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account:

_____	_____	_____
Name/Relationship	Name/Relationship	Name/Relationship

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to Foothills Sports Medicine Physical Therapy, Billing Department, 15410 S. Mountain Pkwy. Suite 112, Phoenix, AZ 85044 for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

ATTENDANCE AGREEMENT: Due to the nature of physical therapy, your progress and full recovery are dependent on both our experienced physical therapists, and your active participation and commitment to your appointments. If you need to cancel your appointment, please contact Foothills Sports Medicine at least one day prior to your appointment. If you call to cancel your appointment on the same day as your appointment or if you do not show, a $25.00 cancellation fee will be assessed.

WORKERS COMPENSATION PATIENTS: We are required to inform your Workers' Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

AUTHORIZATION TO COMMUNICATE ELECTRONICALLY: I understand that authorized personnel (including my physical therapist) from Foothills Sports Medicine Physical Therapy may communicate with me regarding scheduling/ appointments, the treatment provided, home exercise programs, and educational/informative content as it relates to my condition. I understand that my protected health information (PHI) will not be communicated electronically. I understand that I have the opportunity to opt-out of future communications at any time using the "unsubscribe" option on any communication via text or email.

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

Printed Name:_____ Date:_____

Patient/Guardian Signature:_____ Date:_____

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PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Gender: ☐ Male ☐ Female Date: _____

Referring Physician: _____ Return Visit Date: _____

Body Part: _____ Date of Injury: _____ Date of Surgery: _____

Occupation: _____ Work Status: ☐ FT ☐ PT ☐ Unemployed

Hobbies: _____ Prior Treatment: _____

Height: _____ Weight: _____

What is the nature of the current injury?

☐ Work Related ☐ Chronic/Reoccurring ☐ Fall ☐ MVA

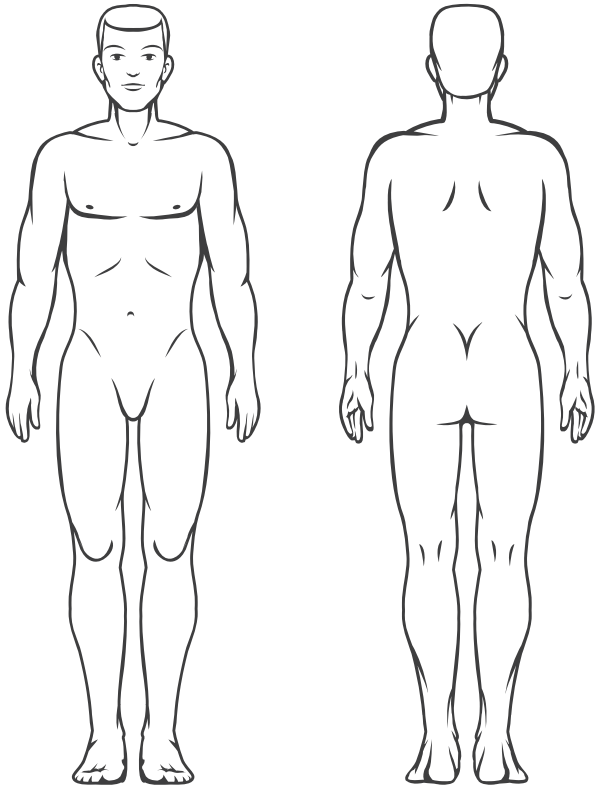
☐ Recreational ☐ Lift or Carry ☐ Insidious ☐ Surgery

What is your pain rating in the last 24 hours? 0-10 Numeric Pain Rating Scale

0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST POSSIBLE PAIN

Please use the diagram provided to mark where your symptoms are currently.



Symbols to Use

Aching: Δ Δ Δ
Stabbing: / / /
Pins & Needles: ○○○
Burning: X X X
Numbness: = = =
Radiates: →→→

My symptoms are made better by: _____

_____

My symptoms are made worse by: _____

_____

My symptoms are:

☐ Constant ☐ Intermittent ☐ Chronic ☐ New

Are your work or activities of daily living limited?

☐ Yes ☐ Partial ☐ No

In addition to this paperwork, you will complete a functional outcomes scale.

PATIENT MEDICAL HISTORY FORM (CONTINUED)

What is your goal for physical therapy? _____

How often do you exercise more than 20 minutes per day?

☐ 1x/wk ☐ 2x/wk ☐ 3x/wk ☐ 4x/wk ☐ 5x/wk ☐ 6x/wk ☐ 7x/wk

Do you smoke? ☐ Yes ☐ No

List any recent Diagnostics (*Xray, MRI, CT Scan, EEG, EMG, Injections*): _____

_____

Do you have any allergies to latex, cold, heat or medications? ☐ Yes ☐ No If yes: _____

Are you on any medications? ☐ Please see attached list provided by the patient.

_____ _____ _____

_____ _____ _____

Are you on any blood thinners? ☐ Yes ☐ No INR: _____

Have you had Home Health Care or a stay with an Inpatient Facility in the last 30 days? If so, please state where:

_____

Have you been discharged? ☐ Yes ☐ No What was the date you were discharged from care? _____

Have you fallen in the last year? ☐ Yes ☐ No If yes, how many times? _____

Did you sustain an injury when you fell, and if so, please describe: _____

Under what circumstances did you fall? (e.g. location, using assistive device, transferring, etc.) _____

_____

Past Medical History

Have you recently noted any of the following? (*check all that apply*)

☐ Changes in Bowel or Bladder
☐ Constipation
☐ Difficulty Swallowing
☐ Dizziness/Lightheaded
☐ Fainting
☐ Fatigue
☐ Fever/Sweats/Chills
☐ Hearburn/Indigestion
☐ Incontinence
☐ Muscle Weakness
☐ Nausea/Vomiting
☐ Numbness/Tingling
☐ Pain that wakes you at night
☐ Rapid Heart Rate/Palpitations
☐ Recent Onset of Headaches
☐ Shortness of Breath
☐ Unexplained Weight gain/loss
☐ Unexplained Cough
☐ Visual Changes

☐ Prior surgeries. Please describe: _____

Have you ever been diagnosed with any of the following? (*check all that apply*)

☐ Anemia
☐ Asthma
☐ Back Pain *(Degenerative, Stenosis, Herniation)*
☐ Bladder/Urinary/Kidney Disease
☐ Bone/Joint infections
☐ Cancer *(any)*
☐ Chest Pain or Angina
☐ Chronic Headaches
☐ Congestive Heart Failure/Heart Attack
☐ Depression/Anxiety/Panic Disorders
☐ Diabetes Type I/Type II
☐ GI Disease *(Liver, Ulcer, Hernia, Reflex, Gall Bladder)*
☐ High/Low Blood Pressure
☐ Lung Disease/COPD/ARDS
☐ Neurological Disease *(MS, Parkinson's)*
☐ Osteoarthritis/Rheumatoid Arthritis
☐ Pneumonia
☐ Seizures or Epilepsy
☐ Stroke/CVA/TIA
☐ TB/HIV/Hepatitis A,B,C
☐ Thyroid Condition
☐ Vascular/Circulation Problems/ Blood Clots
☐ Visual or Hearing Impairments

The above information I have provided is complete, true and correct to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____