MID AMERICA
PHYSICAL THERAPY
PHYSICAL • SPEECH • OCCUPATIONAL

Date: ________________________

Outpatient Therapy Registration Form

Patient Information

Last Name: ________________________________ First Name: ________________________________ MI: __________________

Address: ____ City: ____________________ State: _______ Zip: __________

Home Phone: ______________________ Cell Phone: _______________________ Email: ______________________________

Date of Birth: ______________________________ Social Security # ________________________________ Gender M F

Parent/Guardian (if under age 18) ____

Employer Name: ____ Work Phone: ________________________

Reason for Referral/Diagnosis: ____

Referring Physician: _______________________ Physician's Phone: _______________________

Family Physician: _______________________ Physician's Phone: _______________________

May we send progress notes to your physicians? ☐ Yes ☐ No

Emergency Contact Information

In the rare instance of an emergency, who should be contacted?

Name: __________________________ Phone: _______________________ Relationship: ____________________

Appointment Reminder Service

Complete this information to give your permission to provide automatic appointment reminder service by email or by cell phone text message.

☐ Please send email messages to confirm my upcoming appointments to the email address listed above.

☐ Please send cell phone text messages to confirm my upcoming appointments to ________________________________ cell number.

My cell phone provider is:

☐ AT&T ☐ Cingular ☐ Cricket Wireless ☐ Nextel ☐ Sprint ☐ T Mobile

☐ US Cellular ☐ Cingular ☐ Verizon ☐ Other: ____________________________

Appointment Cancellation Policy

Your therapy success is dependent upon your participation in scheduled appointments. We maintain a strict policy for missed appointments without a 24 hour cancellation notice. **Documentation of any missed appointment is forwarded to your primary physician and caseworker.** *For Worker's Compensation and personal injury, this may jeopardize your claim.*

Please provide insurance cards to therapy staff for benefit verification.

Accident Report / MSP SCREENING FORM

How did your injury/condition occur? ____

____

Was this an automobile accident? ☐ YES ☐ NO

Claim Number: ______________________________

Did this injury happen while at work? ☐ YES ☐ NO

Is this injury part of a WORKER's COMP CLAIM? ☐ YES ☐ NO

If YES, Case Manager Name: ______________________________ Phone Number: ___________________________

Do you have VA benefits or is this treatment authorized by the VA? ☐ YES ☐ NO

Are you currently participating in ANY type of home health service? ☐ YES ☐ NO

If YES, WHERE? ____________________________________ WHEN? ________________________________

Authorization of Assignment of Benefits, Release of Information & Consent for Treatment

I hereby authorize payment directly to Midwest Physical Therapy dba Mid-America Physical Therapy for services rendered and supplies used by Mid-America Physical Therapy therapists and staff. I understand that this assignment is for all benefits otherwise payable to me, but not to exceed my indebtedness to said clinic. I authorize Mid-America Physical Therapy to release any information acquired in the course of treatment and examination. I understand that I am financially responsible to Mid-America Physical Therapy for charges not covered. I authorize the release of any and all medical information necessary to process these claims and I request payment of any benefits to be made directly to Mid-America Physical Therapy. I am also providing my email address and agree to be added to the mailing list. My information will not be sold and is only used for Mid-America Physical Therapy's purposes.

AGE OF CONSENT WHERE MINORS ARE INVOLVED, THE FOLLOWING SHALL PREVAIL:

1. THE CONSENT OF PARENT OR LEGAL GUARDIAN OF PATIENT IF UNMARRIED AND HAS ATTAINED THE AGE OF 18.
2. IF A PATIENT LESS THAN 18 YEARS OF AGE IS MARRIED OR HAS BEEN MARRIED AND SUCH HAS BEEN DISSOLVED BY DISSOLUTION OR ANNULMENT, THEN THE CONSENT OF A LEGAL GUARDIAN IS NOT REQUIRED.

The undersigned further acknowledges that he/she has read and fully understands the foregoing, and has voluntarily signed this document. The undersigning further acknowledges that he/she is the patient, or is duly authorized by and on the behalf of the patient to execute this document; and accepts its term personally upon the patient's behalf. The release of information set forth herein above is valid, and the assignment of benefits and financial agreement is valid and binding until final settlement of the account is received.

PATIENT SIGNATURE: ____ DATE: ____________________

(Parent/Guardian signature required if patient is under age of 18.)

WITNESS SIGNATURE: ____ DATE: ____________________

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Medical History Form

Patient: ____ Date: _________________________________

Have you had a recent injury? ☐ YES ☐ NO

If yes, please check all that apply and describe:

☐ Athletic/Recreational Therapy
☐ Work Related Injury
☐ Cause Unknown
☐ Motor Vehicle Accident
☐ Recurrence of Previous Injury
☐ Other ____
☐ Injury related to a fall
☐ Injury related to lifting

Date of Injury: ______________________________________

Description of Injury: ____

Have you had any falls: ☐ YES ☐ NO

If yes, please describe: ____

Height: ______________________ Weight: ____________________

Do you have any of the following:	YES	NO		YES	NO
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
High Blood Pressure	☐	☐	Allergies to Latex	☐	☐
Heart Disease/Attack	☐	☐	Allergies to Hot or Cold	☐	☐
Heart Attack	☐	☐	Other Allergies	☐	☐
Heart Palpitations	☐	☐	Hernia	☐	☐
Chest Pain/Angina	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Headaches	☐	☐
Are you pregnant?	☐	☐	Dizziness/Fainting	☐	☐
Cancer	☐	☐	Surgeries	☐	☐
Osteoporosis	☐	☐	Skin Abnormalities	☐	☐
Bowel/Bladder Abnormalities	☐	☐	Nausea/Vomiting	☐	☐
Urine Leaking	☐	☐	Ringing in your Ears	☐	☐
Asthma/Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver/Gallbladder Problems	☐	☐	Special Diet Guidelines	☐	☐
Smoking Related Diseases	☐	☐	Hypoglycemia	☐	☐
Stroke/CVA	☐	☐	High Cholesterol	☐	☐
Arthritis	☐	☐	Parkinson's	☐	☐
Neuropathies	☐	☐	Hypo/Hyperthyroidism	☐	☐

Other: _____________________

If yes on any of the above, please briefly explain condition and give approximate date of onset:

____
____
____
____

Is there any other information regarding your past medical history we should know about?

____
____
____
____

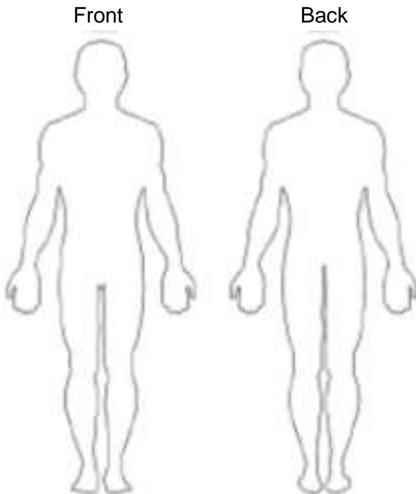
Are you currently taking any medications? ☐ YES ☐ NO If yes, please list medications and why you are taking them:

____
____
____
____

Do you participate in sports or exercise on a regular basis? ☐ YES ☐ NO

What are your personal goals?

1. ____
2. ____
3. ____
4. ____



If you are having pain, please rate the intensity of your pain on a scale of 1 to 10, with 0 being no pain and 10 being the worst pain possible _____________.

Please indicate location of symptoms:

====== Numbness
OOOO Pin & Needles
XXXX Burning Pain
//////// Stabbing Pain

PATIENT SIGNATURE: ____ DATE: ____________________

(Parent/Guardian signature required if patient is under age of 18.)

STAFF SIGNATURE: ____ DATE: ____________________