P R O S P E C T

Rehabilitation

Physical Therapy Services

PATIENT REGISTRATION
MEDICAL HISTORY QUESTIONNAIRE
CONSENT, ASSIGNMENT, AND ACKNOWLEDGEMENT FORMS

Prospect Rehabilitation strives to provide exemplary care in the areas of injury treatment and prevention, health & fitness, and sports conditioning. To help us provide these services and to meet our legal obligations as a health care provider, please answer the questions on the following pages. Thank you.

PATIENT REGISTRATION:

Last Name_____First Name_____Middle Initial____

Mailing Address/City/State/Zip_____

Home Phone #_____Work Phone #_____Date of Birth (m/d/y)_____

Gender:	Marital Status:	Employment Status:	Student Status:
❑ Female	❑ Single	❑ Full Time	❑ Full Time
❑ Male	❑ Married/CU	❑ Part Time	❑ Part Time
	❑ Divorced	❑ Retired	
	❑ Widowed	❑ Not Employed	

Employer Name:_____

Primary Care Physician:_____ Referring Physician:_____

EMERGENCY CONTACTS: Please list two people we could contact in case of an emergency.
Name: _____ Telephone: _____
Name: _____ Telephone: _____

Have you received any in-home medical services or been discharged from an in-patient facility within the past 30 days? __YES __NO

If YES, what organization provided this care, and what was your discharge date?_____

Have you received outpatient physical therapy or speech therapy at this or another location within the past year? ____Yes ____No

If YES, please list the diagnosis and provider: _____

MEDICAL HISTORY

Do you have now, or have you had in the past:

	YES	NO		YES	NO
Heart-related Condition:	❑	❑	Stroke/TIA:	❑	❑
Chest Pain:	❑	❑	Tuberculosis:	❑	❑
Heart Murmur:	❑	❑	Cholesterol Over 240 mg/dl:	❑	❑
High Blood Pressure:	❑	❑	Phlebitis:	❑	❑
Joint Pain/Arthritis:	❑	❑	Ulcers:	❑	❑
Osteoporosis:	❑	❑	Thyroid Disease:	❑	❑
Anemia:	❑	❑	Anorexia/Bulimia:	❑	❑
HIV:	❑	❑	Hepatitis/Liver Disease:	❑	❑
Epilepsy:	❑	❑	Multiple Sclerosis:	❑	❑
Gout:	❑	❑	Cataracts/Glaucoma:	❑	❑
Nose Bleeds:	❑	❑	Blurred/Double Vision:	❑	❑
Ringing in Ears:	❑	❑	Dermatitis:	❑	❑
Fainting/Dizzy Spells:	❑	❑	Asthma/Lung Problems:	❑	❑
Cancer:	❑	❑	Seizures/Neurological Problems:	❑	❑
Diabetes:	❑	❑	Gallbladder/Intestinal Problems:	❑	❑
Back Problems:	❑	❑	Kidney Disease	❑	❑
Hernia:	❑	❑	Physician's Advice not to Exercise:	❑	❑

Alzheimer's, Dementia, Cognitive Deficits or status changes: yes ❑ no ❑

Please list any past surgeries/accidents/hospitalizations and orthopedic or other serious injuries: _____

_____

_____

How would you describe your current level of health? ❑excellent ❑very good ❑good ❑fair ❑poor

Do you have, or has your doctor ever told you that you have a condition that could be aggravated or be made worse by exercise? Yes ❑ NO ❑

Are you over age 65 and not accustomed to vigorous exercise: YES ❑ NO ❑

Are you currently disabled?: YES ❑ NO ❑ If yes: Area:_____ Date Rec'd:_____%____

Are you pregnant, lactating, anticipating becoming pregnant, or pregnant within the past year? YES ❑ NO ❑

Do you have a family history of heart disease in a parent or sibling before age 55: YES ❑ NO ❑

Have you ever been diagnosed with an infection such as HIV, MRSA, etc ? YES ❑ NO ❑

Please list any allergies:_____

Are you currently smoking? YES ❑ NO ❑ If yes, # packs/day:____ If quit, year quit:____

Do you currently take vitamins or dietary supplements: YES ❑ NO ❑

If yes, what kind, how much, and how often? _____

_____

Please list any medications you take on a regular basis, how much, and how often:

I acknowledge that the above information is correct to the best of my knowledge.

Signature:_____ Date:_____

INFORMED CONSENT, ASSIGNMENT, RELEASE OF INFORMATION, and ACKNOWLEDGEMENT FORM

CONSENT: I consent to voluntarily participate in an evaluation and treatment program of physical therapy and/or fitness/sports-related exercise at Prospect Rehabilitation. The tests administered, treatments given, and activities I will perform are designed to stress the body to determine and/or improve physical abilities. Reactions to these tests, treatments, and activities cannot always be predicted with complete accuracy. Though every effort will be made to avoid injury or exacerbation of an existing condition, there are instances when the tests, treatments, or activities referred to above can result in muscle soreness, joint or muscle injury dizziness, nausea, and in extremely rare cases, heart attack or death. I have been instructed to immediately report any ill feelings to the clinician caring for me. I have the right to stop testing or activity at any time, for any reason. No guarantee has been made to me regarding the outcome or effectiveness of my treatment. Any questions I have about testing of the above-mentioned activity have been answered to my satisfaction.

ASSIGNMENT: I authorize payment of medical benefits by my insurance company directly to Prospect Rehabilitation. I authorize Prospect Rehabilitation to be my personal representative, which allows Prospect Rehabilitation to 1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, 2) submit any and all requests for benefit information from my insurance company, and 3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my benefits, within 90 days of any and all appeals or requests for information. I also agree that any fines levied against my insurance company will be paid to Prospect Rehabilitation for acting as my personal representative.

RELEASE OF INFORMATION: I authorize the release of any medical or other information necessary to process this claim and procure payment. I also authorize release of medical information to/from the referring physician and other health care providers involved in my health care.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received a copy of the Notice of Privacy Practices for Prospect Rehabilitation. I understand that my protected health information may be used and disclosed for purposes of treatment and payment as well as other uses outlined in the notice. Prospect Rehabilitation reserves the right to modify the privacy practices outlined in the notice.

Print Name of Patient:_____
Signature of Patient (or legal representative):_____
Date:_____