

Benchmark Physical Therapy & Wellness Center LLC

Registration Form (PLEASE PRINT)

Patient Information

Name _____ Date _____
Last Name First Name Middle Initial

Address _____
Street City State Zip code

Home Phone # (____) _____ Cell (____) _____ Work (____) _____

Sex M F Age _____ Birthday ____/____/____ SS# _____

Single Married Widowed Separated Divorced Driver's License# _____

Patient Employed by _____ Occupation _____

Business Address _____
Street City State Zip code

In case of emergency who should be notified? _____ Phone (____) _____

Person responsible for account _____ Relation to patient _____

Whom may we thank for referring you to our facility? _____

Primary Insurance

Insured's Name _____

(If other than above) Last Name First Name Middle Initial
Relation to patient _____ Birthday ____/____/____ Soc. Sec# _____

Address _____ Phone (____) _____
(if different from patient's) Street City state Zip code

Employed by _____ Occupation _____

Business Address _____ Phone (____) _____
Street City State Zip

Insurance Company _____

ID# _____ Group# _____ Effective Date _____

Secondary Insurance

Is patient covered by additional insurance? Yes No

Insured's Name _____

(If other than above) Last Name First Name Middle Initial
Relation to patient _____ Birthday ____/____/____ Soc. Sec# _____

Address _____ Phone (____) _____
(if different from patient's) Street City state Zip code

Employed by _____ Occupation _____

Business Address _____ Phone (____) _____
Street City State Zip

Insurance Company _____

ID# _____ Group# _____ Effective Date _____

Assignment and Release

I, the undersigned, have insurance coverage with the above stated insurance company and assign directly to Benchmark Physical Therapy & Wellness Center LLC all medial/insurance benefits if any, otherwise payable to our practice for services rendered. I understand that I am financially responsible for any and all charges whether or not paid by insurance, settlement or otherwise. I hereby direct any attorney or insurance company to immediately any and all medial/insurance benefits payable on my behalf to Benchmark Physical Therapy & Wellness Center LLC. I hereby authorize Benchmark Physical Therapy & Wellness Center LLC to release all information necessary to secure the payment of benefits. I realize I am financially responsible for non-covered services. I authorize the use of this signature on all my insurance submissions. I hereby give permission to the therapist and staff to administer treatment and perform such procedures as deemed necessary in the diagnosis and/or treatment of my condition. Accounts past due are subject to collection cost and attorneys fees which I agree to pay.

I consent to care and treatment for the above listed patient, who is a minor, and declare I have guardianship over.

ALL ACCOUNTS OVER 30 DAYS PAST DUE ARE SUBJECT TO 1 1/2% MONTHLY FINANCE CHARGE

Responsible Party Signature

Relationship

Date



PATIENT SELF-EVALUATION

Name _____ Date _____

Medical History: Please check under Yes or No, if you currently have or have had any of the following:

	Yes	No		Yes	No		Yes	No
Currently/Possibly Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (Type)	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain or Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Surgically Implanted Device	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", what kind and where:			Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Etoh (Alcohol) Use	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Fear of Water	<input type="checkbox"/>	<input type="checkbox"/>
Any current or previous history of paralysis or neurological disorders?	<input type="checkbox"/>	<input type="checkbox"/>				Open Wounds	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking a blood thinner or aspirin?	<input type="checkbox"/>	<input type="checkbox"/>						
Any current use or previous history of smoking?	<input type="checkbox"/>	<input type="checkbox"/>						
If quit, when? _____								

List current medications, herbs, and/or over-the-counter drugs you are taking: _____

Any Allergies? _____

List other medical problems and/or prior surgeries with the year they occurred: _____

REASONS FOR PHYSICAL THERAPY

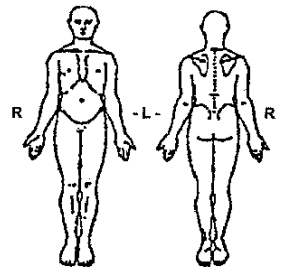
What is your main complaint (i.e. pain, radiating pain, numbness, decreased mobility, problems with activities)? _____

Where is your main complaint located? (Mark on figure) _____

What caused this problem/pain? _____

When did this problem/pain begin? _____

Recent diagnostic tests (X-rays, MRI, etc.): _____



Are you currently employed? Yes No Job Title: _____ How many years at your present job? _____

Last Day of Work: _____ Currently on Medical Leave or Light Duty? Yes No

If yes, please specify: _____

Was this a work-related injury? Yes No _____

Have you had previous therapy/treatment for this problem? Yes No Was it beneficial? Yes No

If yes, what was the treatment? _____

Have you had surgery for this problem? Yes No Date: _____

Have you ever had a similar injury? Yes No

Any special instructions or restrictions from your doctor? _____

What are your goals for treatment? _____

Do you have any objection to your attendant being of the opposite sex? Yes No

Do you object to having your exercises done in an open gym with other patients? Yes No

Reviewed by: _____

Patient Signature

Physical Therapist Signature

FUNCTIONAL ACTIVITIES LIST

The following items are activities you may do during a typical day. Does your health NOW limit you in these activities?

Circle **one** number on each line, as it currently applies to you.

	No, Not Limited At All	Yes, Limited A Little	Yes, Limited A Lot		No, Not Limited At All	Yes, Limited A Little	Yes, Limited A Lot
Sitting, Unlimited	1	2	3	Lifting a gallon of milk	1	2	3
Sitting, 5 min.	1	2	3	Lifting a baby/child	1	2	3
Sitting, 30 min.	1	2	3	Reaching into cabinet	1	2	3
Sitting, 60 min.	1	2	3	Grocery shopping	1	2	3
Rising from seated position	1	2	3	Taking shirt off overhead	1	2	3
Standing, unlimited time	1	2	3	Button shirt/zip zipper	1	2	3
Standing, 10 min.	1	2	3	Fasten bra	1	2	3
Standing, 30 min.	1	2	3	Reaching into back pocket	1	2	3
Standing, 60 min.	1	2	3	Tying shoes	1	2	3
Bending over	1	2	3	Bath/shower	1	2	3
Walking, one block	1	2	3	Getting in/out of tub	1	2	3
Walking, several blocks	1	2	3	Brush/comb hair	1	2	3
Walking, more than 1 mile	1	2	3	Brushing teeth	1	2	3
Going upstairs	1	2	3	Shaving	1	2	3
Going downstairs	1	2	3	Toilet Use	1	2	3
Getting in/out of bed	1	2	3	Driving local	1	2	3
Lying on stomach	1	2	3	Driving, 30 min.	1	2	3
Lying on back	1	2	3	Driving, over 2 hrs	1	2	3
Lying on R/L side	1	2	3	Looking over R shoulder	1	2	3
Sleeping	1	2	3	Looking over L shoulder	1	2	3
Vacuuming/dusting	1	2	3	Getting in/out of car	1	2	3
Washing dishes/cooking	1	2	3	Opening/closing doors	1	2	3
Cutting Grass	1	2	3				