PATIENT REGISTRATION

Name: (Last) _____ (First) _____ **Birth Date:** _____

Home Address: _____ **City** _____ **State** ____ **Zip** _____

Cell phone: _____ **Home phone:** _____

Email: _____

Primary Insurance Company Name: _____

Primary Insurance Holder Name: _____ Birth Date: _____

ID #:_____ Group #:_____

Second Insurance Company Name: _____

Primary Insurance Holder Name: _____ Birth Date: _____

ID #: _____ Group #: _____

Referring Physicians Name: _____

Address: _____ Phone: _____

Reason for Referral: _____

Emergency Contact #: _____ **Relation:** _____

How did you hear about Bercutt Physical Therapy & Wellness Center? Circle One

Doctor Social Media Website Friend or relative other _____

Signature _____ **Today's Date** _____

WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD

AUTHORIZATION RECORD

Initial Each Box

	Authorization for Treatment I give authorization for the performance of such rehabilitation procedures (including dry needle), as permitted by ***Bercutt Physical Therapy*** Statues, under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Medical Information I agree that ***Bercutt Physical Therapy*** may provide information from my medical records to persons involved in my medical care. I authorize the release of medical information necessary to obtain payment of any benefits available to me to ***Bercutt Physical Therapy*** for services rendered. I agree that ***Bercutt Physical Therapy*** may obtain information from others who have provided medical care to me and and/or are responsible for the payment of all or part of my bills, when this information is needed in order to treat, bill and/or receive payment. I have read the "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment I authorize that direct payment of any benefits available to me be released to ***Bercutt Physical Therapy*** for services rendered.
	Patient Agreement I agree to pay ***Bercutt Physical Therapy*** for charges for services rendered to me during my course of treatment. I agree to pay those charges which may not be covered by my health insurance and are my responsibility, per my insurance benefits. I agree that, in the event of a Workers Comp or PIP case, should the responsible insurance party deny coverage or there is no settlement, I am responsible for all therapy charges incurred. If I do not pay for charges that are my responsibility, I agree to pay ***Bercutt Physical Therapy*** collections cost, including attorney and court fees.
	Medicare, Medicaid and similar benefits I agree that the information given to ***Bercutt Physical Therapy*** in applying for benefits under Medicare, Medicaid and Maternal or Child Health Services are complete and accurate. I agree that ***Bercutt Physical Therapy*** may give the Social Security Administration, or its fiscal intermediary's, information necessary to process claims.
	Workers Compensation and/or Auto Accident I agree that the information given to ***Bercutt Physical Therapy*** in applying for benefits under Workers Compensation and PIP is complete and accurate. I agree that ***Bercutt Physical Therapy*** may give any intermediary the necessary information to process claims.

Before continuing, please be sure you have initialed each of the above boxes.

_____	_____	_____
Patient Printed Name	Signature of Patient/Legal Representative	Date

PATIENT HISTORY

Name: _____ **Age:** _____ **Date:** _____

1. Describe the current problem that brought you here?
_____

2. When did your problem first begin? _____

3. Is the problem related to a specific incident? **Y** / **N**

4. Since the first episode is it; staying the ___same ___getting worse ___getting better?

5. Rate pain on a 0-10 scale, 10 being the worst. ____
Describe the nature of the pain _____

6. What makes pain/problem better?_____
Worse?_____

7. Activities/events that cause or aggravate your symptoms. (Check/circle all that apply)

_____Sitting greater than _____minutes
_____Walking greater than _____minutes
_____Standing greater than ____minutes
_____Changing positions (i.e. sit to stand)
_____Light activity (light housework)
_____Vigorous activity/exercise
_____Sexual activity
_____Other, please list _____
_____

_____With cough/sneeze/straining
_____With laughing/yelling
_____With lifting/bending
_____With cold weather
_____With triggers: water/key in door
_____With nervousness/anxiety
_____No activity affects the problem

8. What relieves your symptoms? _____

9. How has your lifestyle been altered because of this problem?
Social activities (exclude physical activities), specify_____
Diet/Fluid intake, specify_____
Physical Activity, specify_____
Work, specify_____
Other_____

10. Rate the severity of this problem from 0 to 10, 0 being no problem, 10 being the worst. _____
11. What are your treatment goals? _____
_____

Since the onset of your current symptoms have you had:

Y/N	Fever/chills	Y/N	Malaise(unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel/bladder function	Y/N	Numbness/tingling

Y/N Other/describe_____

Health History: Date of last physical exam? _____Tests performed _____

_____

General Health (circle)**:** Excellent Good Average Fair Poor

Occupation _____Hours/week _____On disability/leave?_____

Activity restrictions? _____

Mental Health: Stress level (circle): High Med Low **Current psych therapy?** Y/N

Activity/exercise: None 1-2 days/week 3-4 days/week 5+ days/week

Type of Exercise: _____

Do you have a history of falls? Y / **N** When?_____

Have you ever had any of the following conditions or diagnoses? (Circle all that apply)

Cancer	Stroke	Asthma
Heart Problems	Epilepsy/seizures	Allergies (list below)
High Blood Pressure	Multiple Sclerosis	Hypo/Hyper Thyroid
Hearing Loss	Head injury	Headaches
Anemia	Osteoporosis	Diabetes
Low back pain	Chronic Fatigue Syndrome	Kidney Disease
Vision/eye problems	Fibromyalgia	Physical or Sexual Abuse
Alcoholism/Drug problem	Arthritic conditions	Pelvic Pain
Bone Fractures/Breaks	Irritable Bowel Syndrome	HIV/AIDS
Depression/Anxiety	Joint replacement	Sexually transmitted disease
Smoking history	TMJ/neck pain	Hepatitis
Eating Disorders	Lung Issues (list below)	Other/Describe _____

Surgical/Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for female organs	Y/N	Surgery for your abdominal organs

For any Y's please describe_____

Ob/Gyn History *(Females only)*

Y/N	Childbirth vaginal delivery	Y/N	Vaginal dryness
Y/N	Episiotomy	Y/N	Painful periods
Y/N	C-section	Y/N	Menopause- when?_____
Y/N	Difficult childbirth	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic pain

Y/N Other/describe_____

Urology History *(Males Only)*

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Overactive bladder	Y/N	Painful ejaculation
Y/N	Pelvic pain	Y/N	Other/describe _____

Medications- pills, injection, patch	Start Date	Reason for taking

Over the counter- vitamins, etc.	Start Date	Reason for taking

Do you feel safe at home? Y / N

Previous Physical Therapy? (when/where)_____

Are you currently in litigation for any injuries? Y / N

Are you currently receiving any Home Health services? Y / N

If so, you MUST be discharged from Home Health prior to any outpatient services rendered. You do not qualify for Physical Therapy if you are receiving ANY form of Home Health or Therapies (including Skilled Nursing, PT, OT, Speech, Aquatic, etc.). By signing this form, you are admitting responsibility for any denied charges from Insurance for multiple services, on the same day.

_____ _____

Signature Date