



**Patient Registration Information**

Please Print

Full Legal Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 \_\_\_\_\_ ( ) \_\_\_\_\_  
 Address: Street \_\_\_\_\_ Apartment # \_\_\_\_\_ Home Phone Number \_\_\_\_\_  
 \_\_\_\_\_ ( ) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Mobile Phone Number \_\_\_\_\_  
 Male Female \_\_\_\_\_ / / \_\_\_\_\_ Single Married \_\_\_\_\_ ( ) \_\_\_\_\_  
 (circle one) Date Of Birth (circle one) Name of Spouse Spouse Phone Number \_\_\_\_\_  
 Occupation \_\_\_\_\_ ( ) \_\_\_\_\_  
 School Name if student \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone Number \_\_\_\_\_  
 Email Address \_\_\_\_\_ How were you referred to Rehab Plus \_\_\_\_\_

**Insurance Information**

Insurance Company \_\_\_\_\_ ( ) \_\_\_\_\_ Ins Co Phone Number \_\_\_\_\_ Policy ID Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Policy Holder's Name \_\_\_\_\_ / / \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Worker's Compensation Information**

Worker's Compensation Carrier Address: Street \_\_\_\_\_ City, State Zip \_\_\_\_\_  
 Claim Number \_\_\_\_\_ Case Manager \_\_\_\_\_ ( ) \_\_\_\_\_ Case Manager Phone # \_\_\_\_\_  
 / / \_\_\_\_\_ Date of Injury \_\_\_\_\_ Employer at time of injury \_\_\_\_\_ Employer Phone Number \_\_\_\_\_

**RELEASE OF INFORMATION**

I give permission to Rehab Plus to release information to my insurance company, attorney, assignees, and/or beneficiaries.

**ASSIGNMENT OF BENEFITS**

I authorize payment directly to Rehab Plus and Jeff Kitchen, Inc. (Scottsdale) for services I receive. Any payments made to me by third party payer services provided by Rehab Plus will be immediately (within 5 days) transferred to Rehab Plus.

**PAYMENT GUARANTEE**

In consideration of the services rendered and to be rendered to the above named patient by Rehab Plus, I expressly guarantee payment of this account and agree to pay any charges left unpaid in whole or in part by the insurance company. Should this account proceed to collection agency or court, I will be responsible for both the cost of billed services, as well as cost of collections and any and all attorney and court fees associated with the collection process. The patient is ultimately responsible for account totals and balances.

\_\_\_\_\_  
 Signature of Responsible Party or Legal Guardian If Minor Date

By signing above, you, as the patient or legal guardian, agree to the terms and conditions listed under "Release of Information", Assignment of Benefits", and "Payment Guarantee". **Any unilateral alteration, strikeover or modification to the preprinted text or line entries of this document and legal agreement shall be of no effect whatsoever, and at Rehab Plus' sole discretion, may render this document invalid.**

## Patient Medical History Form

Name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

Type of work, examples: lifting, prolonged sitting, standing, etc.

Injury/Reason you are here? \_\_\_\_\_

If you had surgery for this injury, what was the date of surgery? \_\_\_\_\_

### **Past Medical History:**

Do you have any previous history of:

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Pressure Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Knee Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> None Significant	
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other _____	

Which of the following aggravates your condition?

<input type="checkbox"/> Walking	<input type="checkbox"/> Bending	<input type="checkbox"/> Change of Direction	<input type="checkbox"/> Lying Prone	<input type="checkbox"/> Overhead Activities
<input type="checkbox"/> Standing	<input type="checkbox"/> Lifting	<input type="checkbox"/> Up Stairs	<input type="checkbox"/> Lying Supine	<input type="checkbox"/> Impinging Positions
<input type="checkbox"/> Sitting	<input type="checkbox"/> Running	<input type="checkbox"/> Down Stairs	<input type="checkbox"/> Sidelying	<input type="checkbox"/> Prolonged Immobility

What eases your symptoms?

<input type="checkbox"/> Resting	<input type="checkbox"/> Medication	<input type="checkbox"/> Supine with feet elevated	<input type="checkbox"/> Other _____
<input type="checkbox"/> Avoidance	<input type="checkbox"/> Walking	<input type="checkbox"/> Frequent change of position	
<input type="checkbox"/> Modalities	<input type="checkbox"/> Standing	<input type="checkbox"/> None	

Have you been admitted to the hospital or had any surgical procedures during the last 5 years?  Yes  No

What was this condition? \_\_\_\_\_

Is this condition the reason you were referred to physical therapy?  Yes  No

Have you received any physical therapy treatments during the past 5 years?  Yes  No

If yes, for what condition and was the treatment effective? \_\_\_\_\_

Have you had any other previous medical problems or surgeries?  Yes  No

If yes, please specify: \_\_\_\_\_

Did you receive any special tests while in the hospital or as an out-patient? Example: CAT Scan, EMG, EKG, MRI

Yes  No If yes, please specify: \_\_\_\_\_

Have you had any previous orthopedic problems?  Yes  No

If yes, please specify: \_\_\_\_\_

Medications? What type and what for? \_\_\_\_\_

Exercise/Activity level: \_\_\_\_\_ 0 days/week \_\_\_\_\_ 1-2 days/week \_\_\_\_\_ 3-5 days/week \_\_\_\_\_ 6-7 days/week

What types of activities? \_\_\_\_\_

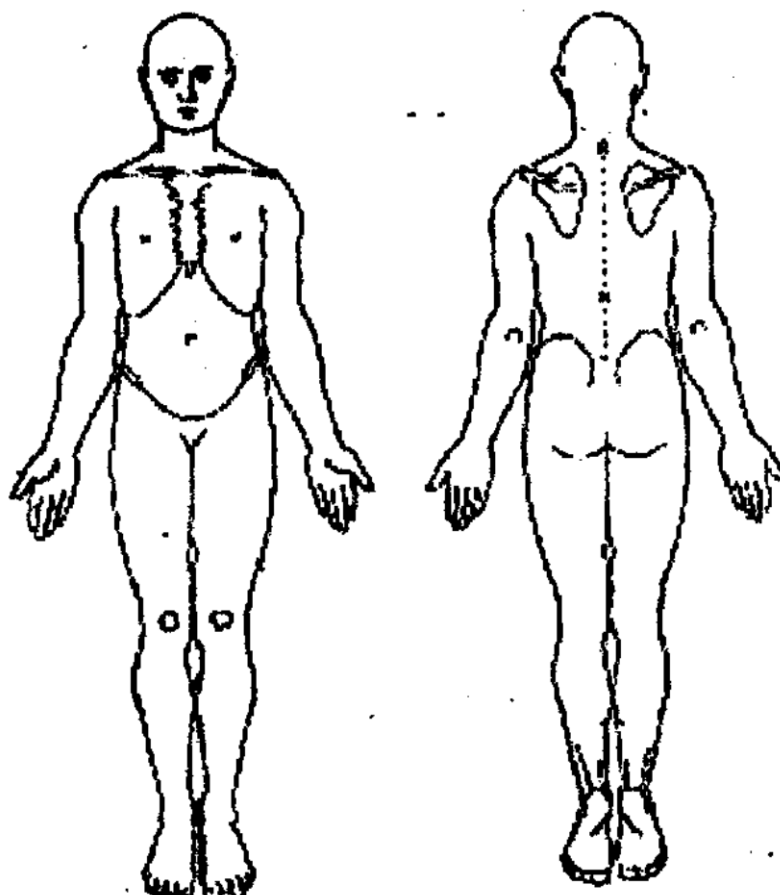
Name of your orthopedic and/or primary doctor? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Please mark the diagram with "xx" where your pain typically presents:



On a scale of 1 to 10, (1 being minimal pain and 10 being excruciating), please rate your overall pain:

at worst: \_\_\_\_\_

at best: \_\_\_\_\_

on average: \_\_\_\_\_

