GARBER
PHYSICAL THERAPY

PATIENT REGISTRATION

Name: (Last) _____ (First) _____ (MI) _____ (Jr., Sr., etc.) Sex: □M or □F

Street Address: _____ Apt./Space: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Marital Status: _____

CONTACT INFORMATION (Check the box next to the best contact number)

□Home phone: _____ □Work Phone: _____ □Cell Phone: _____

Email address: _____

EMERGENCY CONTACT: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PARENT / RESPONSIBLE PARTY FOR PAYMENT: _____ Date of Birth: _____

Address: (If different from above) _____

City: _____ State: _____ Zip Code: _____ Phone: _____

INSURANCE INFORMATION

Primary Ins: _____ **Insured Name:** _____ **DOB:** _____

Secondary Ins: _____ **Insured Name:** _____ **DOB:** _____

On the job injury? □YES □NO

Workers' Comp Insurance Co. Date of Injury: _____ Claim #: _____ Adjuster's Name _____

Auto Accident? □YES □NO Date of Injury: _____ Claim #: _____ Adjuster's Name _____

Attorney's Name: _____ Attorney's Phone: _____

PREVIOUS THERAPY INFORMATION

Have you received any other Therapy Services this calendar year? □YES □NO

Have you received, or are you currently receiving Home Health Therapy? □YES □NO

If yes, please provide dates: _____ and the name of Home Health Agency: _____

Have you received, or are you currently receiving Chiropractic Treatment? □YES □NO

I hereby authorize payment of medical benefits to Garber Physical Therapy, for services furnished to me. I also hereby consent to have treatment and care as prescribed by my physician and / or recommended by the therapist. I also authorize the therapist to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I HEREBY ACCEPT FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED WHETHER OR NOT I HAVE INSURANCE COVERAGE. VERIFICATION OF BENEFITS WE RECEIVE FROM YOUR INSURANCE COMPANY IS NOT A GUARANTEE OF PAYMENT.

_____ _____

Patient or Responsible Party Signature Date

GARBER PHYSICAL THERAPY

MEDICAL HISTORY FORM

NAME: _____ DATE: _____

REFERRING PHYSICIAN: _____ DATE OF BIRTH: _____

FAMILY PHYSICIAN: _____

MEDICAL HISTORY

Is your current condition related to an injury? ☐Yes ☐No

If YES, was the injury related to: ☐Auto ☐Work ☐Other _____ **Date of Injury** _____

Are there any lawsuits pending regarding your condition? ☐Yes ☐No

Have you received physical/speech therapy in the last year? ☐Yes ☐No

If YES, refer to your insurance policy for limitations.

Please check any of the following conditions you have or may have had in the past:

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Mood Disorders
- ☐ Shortness of Breath
- ☐ Kidney Disease
- ☐ Dizzy Spells Headaches
- ☐ Loss of Bladder/Bowel Control
- ☐ Tuberculosis
- ☐ Currently Pregnant
- ☐ Pacemaker
- ☐ Chest Pain/Discomfort
- ☐ Ankle Swelling
- ☐ Epilepsy/Seizures
- ☐ Allergies
- ☐ Cancer: Type _____
- ☐ Other: _____
- ☐ Asthma
- ☐ Stroke
- ☐ C.O.P.D.
- ☐ Hepatitis
- ☐ Anemia
- ☐ Diabetes
- ☐ Hernia

ORTHOPEDIC LIMITATIONS

Please check any of the following conditions that you have or have had in the past:

- ☐ Osteoporosis
- ☐ Broken Bones
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Slipped/Ruptured Disc
- ☐ Weakness
- ☐ Compression Fractures
- ☐ Scoliosis
- ☐ Sprains/Strains
- ☐ Balance/Walking Problems
- ☐ Limited Range of Motion
- ☐ Subluxed/Dislocated Joints
- ☐ Painful Grinding/Cracking in a Joint

Have you had a recent: ☐ X-Ray ☐ MRI ☐ CT Scan

If so, when? _____/_____/_____

Please list hospitalizations or surgeries you have had:

_____

_____

Please list any medications you are currently taking:

_____

Are you allergic to any medications: ☐ Yes ☐ No If yes, please list: _____

Signature: _____ Date: _____

PT Signature: _____ Date: _____