

PATIENT INFORMATION					
Patient's Last Name		First	Middle	How would you like to be addressed?	
Street Address		City	State	Zip Code	
Home Phone	Work Phone	Cell Phone		Social Security # (billing purposes)	
Occupation		Date of Birth		Age	Sex M / F
Primary Care MD		Employer		Employer Address	
Prescribing Physicians Name	Date of Last Phys. Appt. / /	Date of Next Phys. Appt. / /		How did you hear about our office?	

Are you here for treatment resulting from a work injury? Yes / No

Date of injury / / Claim #

Are you here for treatment resulting from a car accident? Yes / No

Date of Accident / / Claim # Insurance Company

If you have an attorney, what is the name of your attorney.....

IN CASE OF EMERGENCY			
Contact Name	Relationship to Patient	Home Phone	Work Phone

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN

.....

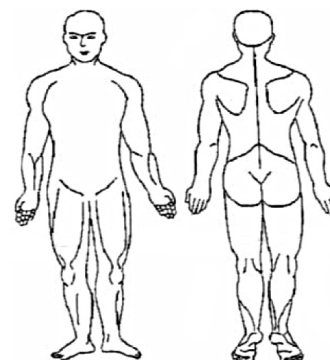
Mark an X on the picture where you have pain or other symptoms

Can you perform your daily activities? Yes / No (Describe)

.....

Have you ever had physical therapy for this condition? Yes / No Year:

Current complaint (how do you feel today):										
.....										
0	1	2	3	4	5	6	7	8	9	10
No Pain								Unbearable Pain		



Your Email Address



client registration

P: 360.752.CORE | F: 360.752.0271 | www.corept.org

2 of 2

HAVE YOU RECENTLY NOTICED?								
Y /	N	Weight Loss/ Gain	Y /	N	Weakness	Y /	N	Dizziness
Y /	N	Nausea/Vomiting	Y /	N	Fever/Chills/Sweats	Y /	N	Bladder/Bowel Changes
Y /	N	Fatigue	Y /	N	Numbness or Tingling	Y /	N	Chest Pain
HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?								
Y /	N	Heart Problems	Y /	N	Hearing Loss/Disorder	Y /	N	Cancer
Y /	N	High Blood Pressure	Y /	N	Eye Disease	Y /	N	Osteoporosis
Y /	N	Circulation Problems	Y /	N	Muscular Disease/Disorder	Y /	N	Depression
Y /	N	Rheumatoid Arthritis	Y /	N	Multiple Sclerosis	Y /	N	Past Pregnancy
Y /	N	Other Arthritic Conditions	Y /	N	Tuberculosis	Y /	N	Current Pregnancy
Y /	N	Stroke	Y /	N	Epilepsy/Seizures	Y /	N	Chemical Dependency
Y /	N	Lung Disease	Y /	N	Hepatitis	Y /	N	Ulcers
Y /	N	Asthma	Y /	N	Kidney Disease	Y /	N	Diabetes
Y /	N	Pacemaker	Y /	N	Thyroid Problems	Y /	N	Implanted Devices

LIST SURGERIES, MEDICAL CONDITIONS OR INJURIES FOR WHICH YOU HAVE BEEN TREATED:

.....

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (PILLS, INJECTIONS, INHALERS, ETC.):

.....

By initialing the following statements I am acknowledging that I have fully read and understand each statement.

- It is my responsibility to completely understand my insurance benefits for Physical Therapy and understand that I am financially responsible for ALL CHARGES not covered by my insurance.
- I further authorize payment directly to *Core Physical Therapy - the specialty clinic*.
- I authorize *Core Physical Therapy - the specialty clinic* to release any and all information concerning my PT care to my insurance company and my referring physician(s).
- I understand as a self pay client payment is due at the time of service.
- I understand that if I cancel more than 48 hours in advance, I will not be charged. I understand that if I cancel less than 48 hours in advance or fail to come to a scheduled appointment, I will pay a cancellation fee of \$30.00.
- If I incur an appointment cancellation charge, I will pay the \$30.00 fee at or before my next appointment.
- I understand that the staff of Core PT cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me his/her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.
- I understand that in order for physical therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.
- I have reviewed the Notice of Privacy Practices and have been given a copy at my request.

.....
Name: _____ Birth Date: _____

.....
Signature: _____ Date: _____