PRINT

AGOURA HILLS PHYSICAL THERAPY

Patient Registration Information
Please Print Clearly

Patient's Name_____ M/F Age_____ Birth Date_____/_____/_____
Last First

Address_____
Street City Zip

Home Phone_____ Bus. Phone_____ Cell Phone_____

Email address_____ (for appointment reminders and exercise programs)

Responsible party if under 18_____

Employer_____ Occupation_____

Address_____
Street City Zip

Emergency Contact_____
Name Phone Number

Primary Insurance

Insured Name_____ Birth Date_____
Relationship to patient_____

Secondary Insurance

Insured Name_____ Birth Date_____
Relationship to patient_____

I hereby irrevocably authorize payment of medical services rendered to myself or my dependent(s) directly to Agoura Hills Physical Therapy. I also authorize same to furnish my insurance with full information regarding treatment rendered to me or my dependent(s). I also understand that my insurance is billed as a courtesy, and that I am responsible for all charges not paid by my insurance within six weeks after billing date.

The Health Insurance Privacy & Accountability Act of 1996 (HIPAA) if a federal program that requires all medical records and other individually protected health information used or disclosed by us in any form, electronically, paper, or orally are kept confidential. This act gives you, the patient, significant new rights to understand and correct how your health information is used. Our practice is committed to securing the privacy of your health information. Accordingly, we have posted a brief explanation of our Privacy Practices in our office, and have made available a copy of the entire policy at your request. We would like your acknowledgement that you have been notified of the HIPAA program and Notice of Privacy Practices in our office.

Patient Signature:_____ Date_____

Relationship if not signed by Patient_____

AGOURA HILLS PHYSICAL THERAPY
PATIENT HEALTH QUESTIONNAIRE

Name:_____Date_____

Please describe your current complaints or limitations: _____

_____

Please describe how and when your problem began:_____

_____

Specific Date if possible:_____

Have you received / are you currently receiving any Home Health? YES or NO If yes, when:_____

Did you have surgery for this condition? YES or NO If yes, when:_____

Please describe the nature of your pain:

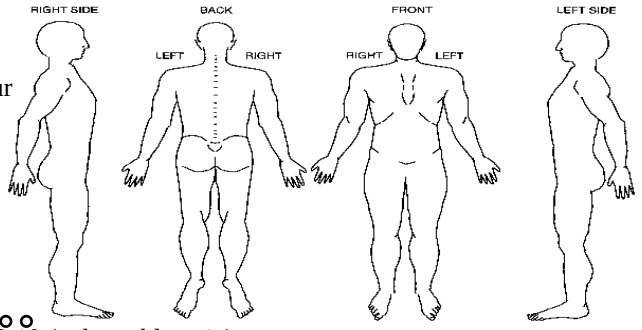
□Sharp □Constant (76-100%) Mark on the picture where your

□Dull/Achy □Frequent (51-75%) pain or symptoms are →

□Throbbing □Occasional (26-50%)

□Numbness □Intermittent (25 or less)

□Shooting □Burning



Please indicate the intensity of *pain at rest*: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Please indicate the intensity of *pain with movement*: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Since this condition began, have your symptoms: □decreased □not changed □increased

Your symptoms are worse in: ☑morning □afternoon □night □same all day

If you have ever had a listed condition, please check in the **YES** column. By providing this information, it allows your therapist to have a thorough understanding of your state of health.

YES	NO	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Heart Disease
☐	☐	Pacemaker
☐	☐	Osteoporosis
☐	☐	Diabetes
☐	☐	Seizures
☐	☐	Stroke
☐	☐	Arthritis
☐	☐	Pregnancy
☐	☐	Recent Weight Loss/Gain
☐	☐	Metal Implants
☐	☐	Circulation Problems
☐	☐	Cancer Location:_____Date:_____
☐	☐	Muscle Weakness
☐	☐	General Fatigue
☐	☐	Other

Hospitalization/Surgical Procedures:
(list if not described elsewhere)

_____

_____

_____

_____

Medications: _____

_____

_____

_____

_____

How did you hear about us?_____

Signature_____Date_____