PROBILITY
THERAPY SERVICES

PATIENT REGISTRATION FORM

Last Name | First Name | MI | DOB | Sex | SSN

Address | City/State/Zip | Marital Status

Home Phone # | Cell Phone # | E-mail Address

Employer Name | Employer Phone | Current Position

Employer Address | City/State/Zip

IN CASE OF EMERGENCY

Contact's Full Name | Relationship to Patient | Cell Phone # | Other Phone (Optional)

GUARANTOR

(Guarantor info required if patient is under 18; Please state the name, phone number, and address of the person financially responsible for all balances relating to this patient.)

Guarantor Full Name | Address

City/State/Zip | Guarantor Phone # | Relationship to Patient

I HEREBY ASSIGN ALL MEDCAL BENEFITS TO WHICH I AM ENTITLED TO PROBILITY THERAPY SERVICES IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS.

A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF PROBILITY THERAPY SERVICES AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE. I CONSENT TO BEING KNOWINGLY PHOTOGRAPHED OR VIDEOTAPED BY AUTHORIZED PERSONEL OF PROBILITY PHYSICAL THERAPY FOR MEDICAL REASONS SUCH AS POSTURAL CORRECTION, GAIT/MOVEMENT ANALYSIS OR EDUCATIONAL PURPOSES.

After reviewing the corresponding policies, please initial next to each statement:

I acknowledge that I have read, understand and agree to the **Notice of Patient Information Practices** _____

Probility may not sell or disclose protected health information to a business associate or any other third party for that party's own marketing purposes. By signing this form, you authorize Probility to contact you regarding marketing of health-related products and services through email or postal mail. If you wish to ***OPT OUT*** *of such marketing materials, please check this box:* ☐

I acknowledge that I have read, understand and agree to the **Cancellation/No-Show Policy** _____

I acknowledge that I have read, understand and agree to the **Notice of Billing Department Policies** _____

_____ _____

Authorized Signature (parent signature for minors) **Date**

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INITIAL PATIENT QUESTIONNAIRE

Name: _____ Date: _____

1. What are your symptoms? _____
_____
_____
_____
_____

2. Which of the following best describes how your injury occurred? (Check only one):
☐ Lifting ☐ Trauma ☐ Cumulative trauma / overuse
☐ Car accident ☐ Degenerative process ☐ Unknown
☐ A fall ☐ During recreation/sports ☐ Other: _____
☐ Running

3. Where did your injury occur?
☐ at work ☐ auto ☐ personal home ☐ other premise _____ ☐ unsure

4. Date of injury / onset of symptoms: _____
_____

5. Nature of symptoms (check all that apply):
☐ sharp ☐ dull ☐ aching ☐ tingling
☐ occasional ☐ constant ☐ throbbing ☐ other _____

6. Please state your pain level on a scale of 0 – 10 (0 = no pain, 10 = hospitalized by pain): ___ /10

7. Prior to this onset, were you free of these symptoms? Yes _____ No _____

Explain: _____
_____

8. Have you had any operations on the body region associated with your present symptoms?

☐ No ☐ Yes, date: _____ Procedure: _____

Please list any other surgeries you may have had: _____
_____
_____

9. Does the pain wake you at night?
☐ Yes ____x/night ☐ No

10. When are your symptoms the most severe?
Time of day: ☐ Morning ☐ Afternoon ☐ Evening ☐ No difference
Position: ☐ Sitting ☐ Standing ☐ No difference

12. What makes your symptoms worse? (check all that apply):

☐ Sitting	☐ Coughing/sneezing	☐ Reaching out/overhead	☐ Stress
☐ Going to/from sitting	☐ Taking a deep breath	☐ Reaching behind back	☐ Vacuuming
☐ Standing	☐ Sustained bending	☐ Looking up overhead	☐ Doing dishes
☐ Squatting	☐ Chewing	☐ Up/down stairs	☐ Making the bed
☐ Walking	☐ Swallowing	☐ Up/down an incline	☐ Other_____
☐ Lying down	☐ Sleeping	☐ Sports/recreation such as _____	

13. What relieves / lessens your symptoms?

☐ Sitting	☐ Changing positions	☐ Exercise	☐ Stretching
☐ Standing	☐ Rest	☐ Heat	☐ Massage
☐ Lying down	☐ Alcohol	☐ Cold	☐ Nothing

☐ Other: _____

14. What previous treatment have you had?

☐ Physical Therapy	☐ Massage therapy	☐ Bracing/taping
☐ Exercise	☐ TENS unit	☐ None
☐ Medication	☐ Traction	☐ Other: _____
☐ Injections	☐ Manipulation/adjustment by a Osteopath or Chiropractor	

15. Have you had any of the following?

☐ X-rays ☐ MRI ☐ CT Scan ☐ Arthrogram ☐ Other: _____

16. Are you currently working?

☐ Yes ☐ No ☐ Part-time ☐ Full-time ☐ Restricted duty

Occupation (specific): _____

17. What positions are you in while working?

☐ Standing ☐ Sitting ☐ Walking

☐ Bending ☐ Lifting: _____ lbs. _____ times a week

18. Please list any activities that you can't do now because of your injury / symptoms:

_____

_____

19. What goals would you like to achieve from therapy? _____

_____

_____

_____

_____

THERAPIST SECTION

How did the patient hear about us? _____

Patient has been made aware of diagnosis and prognosis: ☐ Yes ☐ No

Discussed goals with patient: ☐ Yes ☐ No

Therapist Signature: _____ Date: _____

PROBILITY
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MEDICAL SYSTEMS REVIEW

Name: _____ Date: _____ Age: ____ Height: _____ Weight: _____

Are you latex sensitive? ☐ Yes ☐ No
Do you smoke? ☐ Yes: _____ Packs/day ☐ No

Do you have a pacemaker? ☐ Yes ☐ No
Women - Are you currently pregnant? ☐ Yes ☐ No

Have you **recently** noticed any of the following? (check all that apply):

☐ Fatigue
☐ Fever / chills / night sweats
☐ Weight loss
☐ Fainting / Dizziness
☐ Nausea / vomiting
☐ Diarrhea
☐ Coughing / Shortness of Breath
☐ Abdominal pain
☐ Constipation
☐ Heartburn / indigestion
☐ Difficulty swallowing
☐ Falls / Loss of balance
☐ Headaches
☐ Muscle weakness
☐ Bleeding / bruising easily
☐ Nail bed changes
☐ Urine color change
☐ Concussion
☐ Infection
☐ Skin changes
☐ Changes in bowel / bladder function
☐ Other _____

Have you **ever** been diagnosed with any of the following? (check all that apply):

☐ Cancer
☐ Heart/cardiac problems
☐ Chest pain / Angina
☐ High blood pressure
☐ Rheumatoid Arthritis
☐ Blood clots
☐ Ulcers
☐ Kidney Disease / Infection
☐ Asthma
☐ Pneumonia
☐ Spina Bifda
☐ Depression
☐ Lung problems
☐ Tuberculosis
☐ GERD / Gastrointestinal problems
☐ Circulation / Vascular problems
☐ Other arthritic conditions
☐ Bladder / Urinary Tract Infections
☐ Hepatitis / Liver Disease
☐ Sexually Transmitted Disease / HIV
☐ Pelvic Inflammatory Disease
☐ Lupus
☐ Thyroid problems
☐ Diabetes
☐ Osteoporosis
☐ Multiple Sclerosis
☐ Epilepsy
☐ Stroke
☐ Anemia
☐ Bone or joint infection
☐ Alcoholism
☐ Drug dependency
☐ Other: _____

Has anyone in your immediate family (parents, brothers, sisters) **ever** been diagnosed with any of the following (check all that apply)?

☐ Cancer
☐ Heart/cardiac problems
☐ High blood pressure
☐ Depression
☐ Osteoporosis
☐ Blood clots
Diabetes
☐ Thyroid problems
☐ Other: _____

During the past month, have you been feeling down or depressed? ☐ Yes ☐ No

Do you feel safe in your home? ☐ Yes ☐ No

FLIP OVER →

MEDICATIONS

List medications (including prescribed pills, skin patches, injections, vitamins/supplements and over the counter medicines) you are currently on and their prescribed purpose. Attach list if needed.

Medication Name	Dosage/Frequency	Prescribed Purpose	Administered (check one):
			☐ Oral ☐ Injected ☐ Cream ☐ Other: ____________________
			☐ Oral ☐ Injected ☐ Cream ☐ Other: ____________________
			☐ Oral ☐ Injected ☐ Cream ☐ Other: ____________________
			☐ Oral ☐ Injected ☐ Cream ☐ Other: ____________________
			☐ Oral ☐ Injected ☐ Cream ☐ Other: ____________________
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			☐ Oral ☐ Injected ☐ Cream ☐ Other: ____________________