seattle physical hill therapy
Sport & Spine

13119 Seattle Hill Road, Suite 107
Snohomish, WA 98296
Phone: 425.224.4490
FAX: 425.224-4491
www.seattlehillphysicaltherapy.com

PATIENT REGISTRATION

please print

Patient _____ Today's date _____
Last First Middle

Address _____
City State Zip

Phone ( ) _____ ( ) _____ ( ) _____
Home Work Cell

Birthdate_____ SS# _____ ☐Male ☐Female

Marital Status _____ **Employed** ☐Full time ☐Part time Student ☐Full time ☐Part time

Employer/School _____ Occupation _____

Employer/School Address _____ Phone _____
City State Zip

Physician's Name _____ Phone _____

Can we can send your statements by Email? No lists, newsletters or junk mail.

Email address _____ How did you hear about us? _____

Parent Name (if patient under 18): _____ Parent Email _____

Emergency Contact Name: _____ Relationship to Patient _____

Emergency Phone Number _____ Can we discuss your condition with this person? _____
Home/Cell/Work

Insurance Information

Primary:_____ Insured's Name:_____ Insured's Birthdate:_____

Secondary:_____ Insured's Name:_____ Insured's Birthdate:_____

Please continue onto other side

Patient Consent

Print Name: _____

Medical Treatment: I hereby consent to and permit appropriate and necessary physical therapy treatment from Seattle Hill Sport and Spine Physical Therapy (SHPT) as deemed necessary during my care.

Release of Information: I hereby authorize SHPT to release any or all of my medical information from and to my physician, my insurance companies, and other third party sponsors necessary to facilitate my care, processing of claims and payments for my physical therapy treatment.

Medical Records: SHPT keeps a record of the health care services provided to me. I may ask to see, copy and/or to add an amendment/correction to that record. SHPT will not disclose my records to others, other than stated above, unless directed by me to do so or unless the law authorizes to do so.

Financial Agreement: I agree: To release all information needed by SHPT to obtain payment from my insurance company, health care plan or payer. To assign to SHPT all insurance benefits payable for services rendered. To pay SHPT in a timely manner for any uncovered services or balances remaining after insurance benefits. To notify SHPT of any changes to my insurance coverage and/or address or phone number.
I have received a copy of the **Patient Intake form with the Billing and Payment Policy** with information regarding my insurance plan benefits for physical therapy. I accept it is my responsibility to contact my carrier for a full understanding of my plan's benefits and to pay 'patient responsibility' portions of my bill for deductible and co-insurance amounts.

I understand that:
I have the responsibility to be truthful and express my concerns clearly to my physicians and provide complete medical history. That I need to keep my appointment times, or cancel in a timely manner. If I am eligible for financial assistance, my bill may be reduced or waived. If I dispute to pay the bill, SHPT will not negotiate with a third party for me. It is my responsibility to understand my insurance benefits, pay my SHPT bill on time, settle the dispute and/or collect from the third party.

Notice of Privacy Practices:
SHPT abides by HIPAA and Washington State Regulations and is able to provide you with detailed information regarding such regulations.

Yes, I understand my Privacy Regulations.
I agree to release medical information to process insurance claims.
I give permission to SHPT to leave a voice message when trying to reach me.
SHPT may discuss my medical condition with _____ (spouse, sig. other, guardian, etc)

Signed_____ **Date**_____

Guardian or Responsible Party: _____
Name Phone

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PHYSICAL THERAPY QUESTIONNAIRE

Patient Name: _____ Date: _____

Physician: _____ Date/Onset of Injury: _____

Please describe the problem you are here for today, how and when it occurred, and location of pain/discomfort:

_____

_____

Since onset, are your symptoms getting:
☐ Better ☐ Worse ☐ Not changing

Have you had similar symptoms in the past?
☐ No ☐ Yes, describe:

What type of pain are you experiencing?
☐ Throbbing ☐ Tingling ☐ Shooting ☐ Occasional
☐ Sharp ☐ Burning ☐ Dull
☐ Aching ☐ Numbness ☐ Constant

As the day progresses, do your symptoms:
☐ Increase ☐ Decrease ☐ Stays the same

Which activities increase your symptoms?
☐ Sitting ☐ Twisting ☐ Lifting ☐ Rising ☐ Kneeling
☐ Bending ☐ Driving ☐ Reaching ☐ Squatting ☐ Standing
☐ Stairs ☐ Coughing ☐ Sneezing ☐ Walking ☐ Reclining
☐ Repetitive motions ☐ Deep breathing ☐ Other: _____

What eases your symptoms?
☐ Heat ☐ Rest ☐ Stretching ☐ Nothing
☐ Ice ☐ Medication ☐ Exercise
☐ Changing position ☐ Other:

Have you had any treatment for this condition in the past?
☐ Yes ☐ No
Please list all: _____

Have you received any of the following tests for this problem?
☐ X-Rays ☐ CT scan ☐ MRI ☐ Bone scan ☐ EMG
☐ Nerve conduction study ☐ Other:
Results:

How would you rate your overall health?
☐ Poor ☐ Fair ☐ Good ☐ Excellent

Are you able to continue your recreational and sporting activities? ☐ Yes ☐ No
Specifics:

What are your goals and expectations for physical therapy? _____

_____

Patient Name:_____

Medical History

Please indicate if you have been diagnosed with the following conditions:

	Yes	No		Yes	No		Yes	No
Allergies			Dizzy Spells			MRSA		
Anemia			Emphysema/Bronchitis			Multiple Sclerosis		
Anxiety			Fibromyalgia			Muscular Disease		
Arthritis			Fractures			Osteoporosis		
Asthma			Gallbladder Problems			Parkinson's		
Autoimmune Disorder			Headaches			Rheumatoid Arthritis		
Cancer			Hearing Impairment			Seizures		
Cardiac Conditions			Hepatitis			Smoking		
Cardiac Pacemaker			High/Low Blood Pressure			Speech Problems		
Chemical Dependency			High Cholesterol			Stroke		
Circulation Problems			HIV/AIDS			Thyroid Disease		
Currently Pregnant			Incontinence			Tuberculosis		
Depression			Kidney Problems			Vision Problems		
Diabetes			Metal Implants					

Please describe any other conditions or precautions:

_____

_____

Fall History:

Injury as a result of a fall in the past year? **Yes____ No____**

Two or more falls in the last year? **Yes____ No____**

Please list any surgeries you have had:

Surgery Date

_____

_____

Please list any prescription or over-the-counter medications you currently take

Medication Name Dose Reason taking

_____

_____

_____

Please list any allergies you may have:

_____

_____

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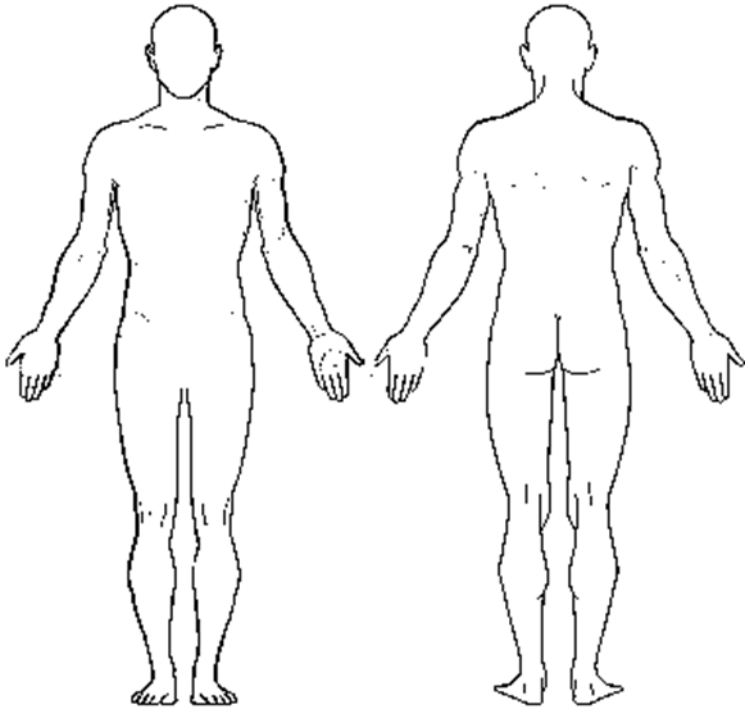
Personal Functional Scale

Patient Name: _____ Body Part:_____ Date: _____

List what activities cause you the most discomfort or inability.

Activity	I cannot perform this activity ↓ Scale	Able to complete at same level as prior to injury ↓
1. _____	|----------	
2. _____	|----------	
3. _____	|----------	



Indicate areas of joint or muscle pain on the diagram above:

Current Level of Pain |----------|

↑ No Pain

↑ Worst Pain Ever Experienced