Patient Registration Form

PATIENT INFORMATION:

Last Name _____ First Name _____

Address _____ Social Security # _____

City/State/Zip _____ ☐Male ☐Female Date of Birth _____

Cell Phone _____ Home Phone _____

Email Address _____

EMERGENCY CONTACT:

Name _____ Relationship _____

Telephone _____

HOW DID YOU FIND OUT ABOUT US?

☐Friend or Family Member Name of Friend _____

☐Physician

☐Internet Search

☐Yelp

☐I am a Returning Patient

☐Drove by

☐Insurance Company

☐Ad

☐Other _____

PHYSICIAN WHO WROTE YOUR PRESCRIPTION:

Name _____ Telephone # _____

Patient Health Questionnaire

To ensure you receive a complete and thorough evaluation, please provide us with the important background information. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

Patient Name:_____ **Weight:** _____ **Height:** _____

I. Please check any of the following whose care you are under:

☐Medical Doctor (MD) ☐Psychiatrist/Psychologist ☐Other _____
☐Osteopath ☐Physical Therapist
☐Dentist ☐Chiropractor

If you have seen any of the above in the past three months, please describe for what reason (illness, medical condition, physical, etc.): _____

II. Have you ever been diagnosed as having any of the following conditions?

Y☐ N☐ 1. Do you wear external protection garments for bladder leakage or incontinence? ☐Day ☐Night
Y☐ N☐ 2. Do you have stress or urge incontinence?
Y☐ N☐ 3. Do you take stool softeners or laxatives?
Y☐ N☐ 4. Cancer. If YES, describe what kind and date of diagnosis: _____
Y☐ N☐ 5. Heart Attack
Y☐ N☐ 6. Heart Arrhythmia
Y☐ N☐ 7. Heart Valve Problems
Y☐ N☐ 8. Do you have a pacemaker?
Y☐ N☐ 9. Deep Venous Thrombosis (Blood Clots)
Y☐ N☐ 10. High Blood Pressure
Y☐ N☐ 11. Circulation Problems
Y☐ N☐ 12. Asthma
Y☐ N☐ 13. Emphysema/Bronchitis
Y☐ N☐ 14. Chemical Dependency (i.e., alcoholism
Y☐ N☐ 14. Thyroid Problems
Y☐ N☐ 16. Diabetes
Y☐ N☐ 17. Multiple Sclerosis
Y☐ N☐ 18. Rheumatoid Arthritis
Y☐ N☐ 19. Other Arthritic Conditions
Y☐ N☐ 20. Depression
Y☐ N☐ 21. Hepatitis
Y☐ N☐ 22. Stroke
Y☐ N☐ 23. Kidney Disease
Y☐ N☐ 24. Anemia
Y☐ N☐ 25. Epilepsy / Seizures
Y☐ N☐ 26. Osteoporosis
Y☐ N☐ 27. Dementia
Y☐ N☐ 28. Other _____

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III. Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization:

	DATE	REASON FOR SURGERY/HOSPITALIZATION
1.	_____	_____
2.	_____	_____
3.	_____	_____

IV. Please describe any significant injuries for which you have been treated (fractures, dislocations, sprains, etc) and the approximate date of injury:

	DATE	INJURY
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

V. Please list all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary supplements you are currently taking:

	MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____

VI. General Health Questions:

1. During the past month have you been feeling down, depressed or hopeless? Y☐ N☐
2. Do you ever feel unsafe at home or has anyone hit or tried to injure you in any way? Y☐ N☐
3. How many cigarettes do you smoke per day?_____ Do you chew tobacco? Y☐ N☐
4. How much caffeinated coffee or caffeine containing beverages do you drink per day?_____
5. How many days per week do you drink alcohol?_____ Average # of drinks per sitting?_____
6. Women: Are you currently pregnant or think that you might be pregnant? Y☐ N☐

VII. Have you recently noted any of the following?

Y☐ N☐ 1. Weight Loss / Gain
Y☐ N☐ 2. Nausea / Vomiting
Y☐ N☐ 3. Fatigue
Y☐ N☐ 4. Weakness
Y☐ N☐ 5. Fever / Chills / Sweats
Y☐ N☐ 6. Numbness / Tingling

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VIII. Other Comments:

_____
_____
_____

_____ _____
Therapist Signature *Date*

Informed Consent to Physical Therapy and Care

I hereby request and consent to the performance of physical therapy treatments and other procedures within the scope of the practice of physical therapy on myself by the physical therapists, physical therapist assistants, aides, or anyone working as an employee for Complete PT Pool & Land Physical Therapy, Inc. who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, ultrasound, phonophoresis, electrical stimulation, iontophoresis, joint mobilization, soft tissue mobilization, manual stretching, and active exercise on land and/or in the pool. I understand that I must disclose all my medical conditions in order for the safest method of treatment to be enacted.

I have been informed that physical therapy is generally a safe method of treatment, but I may have some side effects, including skin rash, bruising, muscle soreness, pain, fatigue, numbness or tingling. Unusual risks of physical therapy include fracture, nerve damage, joint dislocation, fainting, myocardial infarction, paralysis and death. There is a risk of infection, although the clinic maintains a safe and clean environment. Burns and/or scarring are a potential risk of iontophoresis, ultrasound, phonophoresis, heat, ice, and taping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I understand that some modalities and exercises may not be appropriate with other medical conditions including coronary artery disease, hypertension, cancer or pregnancy and I will notify a clinical staff member if I have a history of, currently have, or am newly diagnosed with any conditions while under CompletePT Pool & Land Physical Therapy's care.

I have been instructed to wear closed pool shoes to and from the pool as well as in the locker room for my safety. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks best at the time, based upon the facts then known in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential. CompletePT Pool & Land Physical Therapy may disclose protected health information about me to carry out treatment, payment and healthcare operations. I give permission to CompletePT to release my records to my referring physician and my primary care physician. I will refer to HIPPA guidelines for a more complete description of such uses and disclosures. I understand the clinic may call my home or other designated location and leave a message via voicemail or in person in reference to any items that assist in carrying out my care, such as appointment reminders, insurance, prescription information, etc. The clinic may also contact me via mail to my home or other designated location, with information regarding my care. I have the right to request information be restricted, however I understand that my request may be denied if it interferes with my care.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment and release of information. I have been told about the risks and benefits of physical therapy and other procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient or Representative Signature: _____ ***Date:*** _____

I verify that I have informed the patient of the above information and he/she appears to have a clear understanding of the risks and benefits of physical therapy as well as the privacy policies held by CompletePT Pool & Land Physical Therapy, Inc.

Therapist Signature: _____ Date: _____

Only For Patients 60 and Over

Name _____

ELDER ABUSE SUSPICION INDEX © (EASI)			
EASI Questions **Q.1-Q.5 asked of patient; Q.6 answered by doctor** **Within the last 12 months:**			
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did not answer
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES	NO	Did not answer
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer
6) Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	Not sure

The EASI was developed* to raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of "yes" on one or more of questions 2-6 may establish concern. The EASI was validated* for asking by family practitioners of cognitively intact seniors seen in ambulatory settings.

*Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI) ©. Journal of Elder Abuse and Neglect 2008; 20(3) 000-000. In Press. Haworth Press Inc: http: //www.HaworthPress.com

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