EVERGREEN
PHYSICAL THERAPY

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PATIENT REGISTRATION

Patient's Name _____ Date of Birth ___/___/_____

Guardian (If minor) _____ Relationship _____

Patient's Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Email Address _____

I would like to receive appointment reminders via ☐ Email ☐ Text or ☐ Phone Call

Emergency Contact _____ Phone _____

Relationship to Patient _____

Referring Physician _____ Phone _____

Diagnosis _____

Date of Injury / Onset / Surgery: _____

Was This Related to an Accident? Auto/ Work / Other Date of Accident _____

Have you had prior Physical Therapy, Occupational Therapy, Chiropractic, or Acupuncture visits this year? Yes / No If yes, how many visits? _____

Are you currently, or have you received Home Health Services this year? Home Health services can be, but are not limited to nurse, physical therapy, occupational therapy, wound care, IV or other medication administration. Yes / No

If yes, have you been discharged? Yes / No Date of Discharge _____

* Please note that if you have Medicare and are currently receiving Home Health services, you may not begin outpatient physical therapy without first being discharged from Home Health.

EVERGREEN
PHYSICAL THERAPY SPECIALISTS

LASER MEDICAL HISTORY

Patient Name: (Print) _____ **Date:** _____

Medical History: Are you currently experiencing or have you had any of the following:

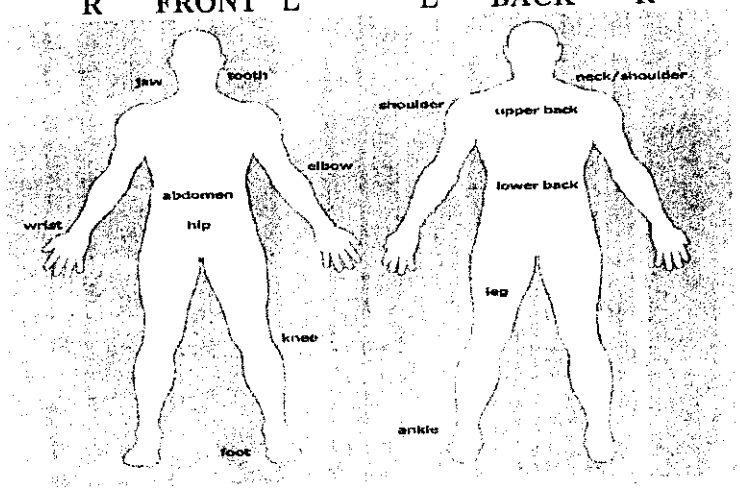
High Blood Pressure	Y N	Heart Disease	Y N	Numbness	Y N
Bowel/Bladder Problems	Y N	Pacemaker	Y N	Cancer	Y N
Shortness of Breath	Y N	Weakness	Y N	Pregnant	Y N
Blood Clots	Y N	Diabetes	Y N	Dizziness	Y N
Night Pain	Y N	Fatigue	Y N	Osteoporosis	Y N
Irregular Heart Rate	Y N	Headaches	Y N	Stroke	Y N
				Pelvic Issues	Y N

Are you taking any blood thinners? Y N
Do you have very light sensitive skin (photosensitive)? Y N
Do you currently have any infections/fever? Y N
Do you have Kidney disease? Y N
Are you taking any of the following Medications (please circle):
Antihistamine, Coal tar and derivatives, Antifungals, Contraceptives (birth control), Pheonothiazines, Psoralens, Corticosteroids, Cortisone Sulfonamides, Sulfonylureas, Thiazide Diuretics (water pills), Tetracyclines, Tricyclic Antidepressants, High-dose Vitamin A (ie. Accutane), Immunosuppressant drugs
Recent Surgeries? Y N (List) _____
Do you have any tattoos? Y N
List other medical problems: _____

Currently:
What is your current complaint? _____ When did it start? _____
Due to an injury? Y N (Explain) _____ Illness? _____
Did the symptoms begin: Suddenly or Gradually Previous problems in this area? Y N
Previous therapy for this condition? Y N What effect? _____
_____
Are you getting: Better Same Worse Are you better with rest? Y N
Does activity make you worse? Y N Which activities? _____
What reduces your pain? _____
What can't you do because of your symptoms? _____
What did the Doctor tell you is your diagnosis? _____
Based upon a 0 to 10 scale (0 is none and 10 is severe), what is your pain:
Right now: _____ Highest pain in past 24 hours: _____ Lowest pain in past 24 hours: _____

PLEASE COMPLETE AREAS OF PAIN ON THE BODY DIAGRAM BELOW:

R FRONT L L BACK R



SIGNATURE_____
Date:_____

Informed Consent

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes visible and invisible laser radiation, therefore, appropriate eye protection is required at all times during treatment.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment, you may see immediate results after the first treatment or depending on the severity of your condition you may require several treatments before you begin to feel results.

Increased soreness may occur after your first laser session. This is a normal healing phenomenon known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program.

You are required to complete the Patient Intake Form prior to treatment to ensure that laser therapy is a viable option for you.

- ☐ I understand the above and consent to treatment
- ☐ I understand that failing to complete any part of my treatment program will reduce my chances of success.

Patient Signature

Date

Print Patient Name

Physician

Signature

Evergreen Physical Therapy Specialists, Inc.
Coronavirus Disease 2019
Non-Personnel Questionnaire

If you have been fully vaccinated for two or more weeks, please indicate below your name at the bottom of this form.

All non-personnel (patients, visitors, vendors, etc.) will be asked to complete this form or to verbally attest to the questions posed on each in-person visit. A daily log will be maintained to record verbal attestations.

Please check the **Yes** or **No** boxes; do not check both the yes and no boxes.

1. Have tested positive for COVID-19 in the past 10 days? Yes ☐ No ☐
2. Are you currently awaiting results from a COVID-19 test? Yes ☐ No ☐
3. Have you been diagnosed with COVID-19 by a licensed health care provider in the past 10 days? Yes ☐ No ☐
4. Have you been told that you are suspected to have COVID-19 by a licensed health care provider in the past 10 days? Yes ☐ No ☐
5. Have you had any of these symptoms in the past 48 hours?

Fever over 100.4° or chills	Yes ☐ No ☐
Persistent cough	Yes ☐ No ☐
Shortness of breath/difficulty in breathing	Yes ☐ No ☐
Fatigue	Yes ☐ No ☐
New loss of taste or smell	Yes ☐ No ☐
Sore throat	Yes ☐ No ☐
Muscle or body aches	Yes ☐ No ☐
Congestion or runny nose	Yes ☐ No ☐
Nausea or vomiting	Yes ☐ No ☐
Diarrhea	Yes ☐ No ☐
Headaches	Yes ☐ No ☐

In order to comply with OSHA's Emergency Temporary Standard for exempt outpatient providers we are prohibited from allowing COVID-19 positive or suspected positive individuals from entering our facility past our screening point. We will make every attempt to provide patient treatments via telehealth, in these situations if permitted by law. Should this not be available we will provide a list of potential facilities that may be available for continued treatment during this restriction period.

Name: _____ Date: _____

Vaccinated: Yes ☐ No ☐

This Information is Highly Confidential & Will be Securely Managed

Exhibit B2 Non-Employee/personnel 6-24-2020, 8-25-20 rev, .11-23-20 rev. 1-28-21 rev, 4-12-21 rev. 6-25-21 rev.